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IMPROVING THE HEALTH OF THE POOR: A DEVELOPMENT CORNERSTONE

HEARING

BEFORE THE

INTERNATIONAL TASK FORCE

OF THE

SELECT COMMITTEE ON HUNGER
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 6, 1989

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IMPROVING THE HEALTH OF THE POOR: A DEVELOPMENT CORNERSTONE

THURSDAY, APRIL 6, 1989

House of Representatives,
International Task Force,
Select Committee on Hunger,
Washington, DC.

The task force met, pursuant to notice, at 10:05 a.m., in room 311, Cannon House Office Building, Hon. Tony P. Hall [chairman of the task force] presiding.

Members present: Representatives Dorgan, Penny, Foglietta, Faleomavaega, Gilman, and Bereuter.

Also present: Representative Payne.

OPENING STATEMENT OF HON. TONY P. HALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Hall. Good morning. I would like to welcome all of you to this morning's hearing on international efforts to improve the health of people in developing countries. My name is Tony Hall and I am chairman of the International Task Force of the Select Committee on Hunger.

The Select Committee on Hunger believes strongly that A.I.D. programs must work to end poverty and hunger and preventable death and illness. As the Foreign Affairs Committee works to rewrite foreign aid legislation, I hope we keep this in mind. A program that isn't working vigorously to end poverty and hunger and improve human health and well-being doesn't really deserve to be called aid.

I am pleased to welcome a group of people representing organizations which are working to bring about better health for as many people as possible, as quickly as possible.

World Health Day is tomorrow and the select committee hopes to emphasize the importance of improving health for everybody and to get a very important message out: that the efforts of UNICEF, WHO, A.I.D.'s Child Survival Action Program, and thousands of voluntary and private groups are succeeding.

Improved immunization coverage, use of oral rehydration therapy and other child survival techniques have helped create a world where millions more children are laughing and playing than would have been possible 30 years ago.

I think all of us on this committee are proud of the role that Congress has played and certainly proud of the role that the Select Committee on Hunger has played in supporting this effort.

I pledge that my work in this, my work personally will continue. Now, of course, is certainly no time to reduce our commitment to health for all. Finally, I would like to indicate that some of my colleagues: Mr. Leland, Mr. Ackerman, Mr. Emerson, Mr. McNulty, will not be with us today and it is not because they are not interested in the topic, it is because they, in fact, are in Ethiopia and Sudan looking at the situation there and fighting for more food, and better health for people in very desperate situations.

We have quite a set of witnesses today from A.I.D., UNICEF, the World Health Organization, Rotary International, and the Carter Presidential Center. You are certainly welcomed here. We look forward to benefitting from your knowledge. The hearing will be in two panels.

The first will consist of Nyle Brady, Jim Grant accompanied by Audrey Hepburn and Ingar Bruggemann. Nyle Brady is a Senior Assistant Administrator of A.I.D.'s Bureau for Science and Technology.

Jim Grant, of course, is the executive director of UNICEF and Mrs. Bruggemann represents the World Health Organization at the United Nations.

I would ask my colleagues if they have any opening statements. Mr. Bereuter.

OPENING STATEMENT OF HON. DOUG BEREUTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. Bereuter. Thank you, Mr. Chairman; I do. I need to set out a couple of things today of which you are somewhat aware already because of your assistance. I want to say, first of all, that my mind, and especially my heart, will be here with you today in these hearings.

I really greatly regret the fact that my vote is going to be required throughout the day in the Banking Committee where we begin the mark-up today on the savings and loan, FSLIC rescue plan. It is a conflict that I regret, but I do want to thank and commend you for calling the hearings today on the subject of world health.

Tomorrow, April 7th, is World Health Day, a day which commemorates the founding of the World Health Organization 41 years ago. This is also a special moment because of an event that happened 11 years ago at Alma-Ata in the Soviet Union.

At the conclusion of a major international conference on primary health care in September of 1978, jointly sponsored by the World Health Organization and UNICEF, representatives of 134 nations agreed to the terms of a solemn declaration pledging urgent action by all governments, all health and development workers, and the world community to obtain for all of the people of the world by the year 2000, "a level of health that will permit them to lead a socially and economically productive life."

The United States was, of course, one of the supporters of that declaration of Alma-Ata. In 1989, we are exactly half way in time between 1978 and the year 2000. We have a new administration in office headed by a President who has pledged himself to seek a kinder and gentler nation and a nation where the many lights of our outstanding tradition of private, voluntary action are invited to shine.

Even the international arena has given us some unexpected and hopeful signs and surprises in recent months, including a Soviet leadership that is exhibiting new signs of openness and political and military restraint.

I had begun to sense last fall that we were being presented with a truly momentous, historical opportunity in this decade of the 1990's that is upcoming, analogous in many ways to the kind of opportunity that offered itself when the decision was made to put a man on the Moon. We now, for the first time in world history, have the technical means to ensure that no one in the world dies of an easily preventable cause.

We have vaccines. We can produce enough food to feed everyone in the world. Yes, underline that, "we can produce enough food to feed everyone in the world." We have radio and TV and other means of educating even poor or remote or home-bound people.

We have low-cost technology for sanitation, water, and diarrheal diseases. We have the communications, transportation, and managerial technologies to get the needed supplies and people to where they are needed.

We have the amazing proliferation of grassroots associations that have always existed in the United States, now beginning to happen in Asia and Africa and Latin America and the Caribbean.

There is no technical reason that the world community cannot now make a decision to actually do something that has been a dream of mankind for thousands of years, to decide that it will organize itself so that no one, no child, is condemned to a life in which they cannot be productive for want of a critical minimum of food, basic health care, sanitation, and education.

I think we can accomplish this, and I think we can do it by the year 2000 if we set our minds to it as a collective enterprise of the whole world community. Last October, my staff and I, especially Dr. Nelle Temple, began a process of consulting with other people to see if they shared a sense that we can and should work toward the goal of eliminating easily preventable diseases, deaths, and permanent disabilities through the world by the year 2000.

More importantly, these people were asked to share their ideas about how it could be done and what more is needed that is not being done today. We have been touched with senior people from every organization represented at the hearing today, the World Health Organization, UNICEF, A.I.D., Rotary, the Task Force on Child Survival, plus perhaps 50 to 100 more organizations.

We talked to CARE, to Roman Catholic and Protestant and Jewish religious leaders, to leaders of the environmental movement and to leadership of influential and active universities. We have been in touch with the senior leadership of most of the international financial institutions and a number of U.N. agencies. Fortunately, I serve on the right banking subcommittee to do that. We sought input from business leaders and major foundations and grassroots groups.

It is clear that there is a substantial degree of consensus that political leadership, especially by the U.S. President and the Secretary General of the United Nations, could launch the world with great enthusiasm on the concrete objective of obtaining this goal by the year 2000.

Contrary to what many people think, the main missing ingredient now is not money or technology, it is coordination, inspiration, and leadership which harnesses the energies of international, national, and local organizations around the world, public and private, profit and nonprofit, in a cooperative effort with a clear goal and with targets that are achievable.

In January, I laid out the results of this quiet investigation for Secretary of State James A. Baker III who wrote back to me to say that he believed, "this initiative is one which United States should take the leadership role," as I proposed.

Therefore, yesterday with a bipartisan cosponsorship for my colleagues in leadership positions on the Select Committee on Hunger and the Human Rights and International Organizations Subcommittee of the Committee on Foreign Affairs where it will be referred, where I serve, and the Foreign Operations Subcommittee of the Committee on Appropriations.

I introduced this resolution, H. Res. 120, to put the House of Representatives very specifically on record in support of actions to eliminate preventable diseases and deaths, especially among the world's children.

We will be soliciting and welcoming additional cosponsors on all of these key committees and throughout the House, especially from the Select Committee on Hunger members who are in general so obviously committed to these ideas. I thank Chairman Hall for being among those first eight cosponsors.

The resolution calls for specific actions to promote attainment of the Universal Childhood Immunization target by 1990 and "Health for All by the Year 2000."

The President is encouraged to take the leadership role in proposing that a special commission be set up under the auspices of the Secretary General of the United Nations to assist in strategic planning for obtaining the goal through voluntary and coordinated actions by all of those who want to help—national governments, international organizations, and the critically important nongovernmental organizations.

The resolution endorses the call being made by Mr. James Grant of UNICEF for a World Summit on Children, which I would see as an opportunity for governments to pledge themselves to concrete programs of actions, domestically and internationally, to eliminate these unnecessary deaths.

This agenda, I think, is an agenda of productivity. It is not an attempt to address poverty for strictly humanitarian reasons. It is also an agenda of productivity for the peoples of the world.

Again, Mr. Chairman, I want to thank you for your support for this resolution. I particularly want to thank all of the witnesses for their own inspiring leadership in the examples set by their organizations in pursuit of this goal.

The stories they have to tell are the best testimony to why such a sweeping initiative is possible and timely for the whole world community at this moment in history.

Thank you very much.

Mr. HALL. Thank you, Mr. Bereuter.

Congressman Faleomavaega, do you have a statement?

OPENING STATEMENT OF HON. ENI F.H. FALEOMAVAEGA, THE CONGRESSIONAL DELEGATE FROM AMERICAN SAMOA

Mr. **Faleomavaega**. Mr. Chairman, I want to take this opportunity to thank you and certainly my distinguished colleague from Nebraska who just made an eloquent statement concerning the needs of the committee.

As you know, Mr. Chairman, it only has been 2 days since my appointment as a member of the Select Committee on Hunger and I, too, have the same sentiments and feelings about the needs that we have throughout the world and I could not agree more with the leadership of the House and the members on both sides of the aisles to fully support the importance of this committee and its activities.

My membership in the Foreign Affairs Committee gives me a very interesting perception of the fact that while contributing roughly $20 billion toward the economic needs of the world, at the same time, we are putting in a little over $300 billion to build up our military capability to destroy the world, somewhat of a contradiction, perhaps.

I am not saying that we should have let down in our defense needs, but it is the kind of thing that we need to involve ourselves in, to really see where the needs are and certainly to consider more of the needs for humanity and man's inability to provide for our fellow man's needs rather than to destroy.

I do apologize that because of the commitments coming in the next 45 minutes, I will be coming back and forth in the committee hearing, Mr. Chairman, but I certainly look forward to receiving the statements and I will study them carefully, knowing that the organizations represented here truly have been the forefront of providing support for needy people throughout the world.

I am quite familiar with the activities of WHO, the UNICEF in my area of the world, and I am sure that A.I.D. contributes as well in terms of what they do to alleviate these problems that we hear about so often. Yet, they find it very difficult to provide the appropriate, not only monetary expenditure, but the services needed to resolve these two basic problems that we see.

Mr. Chairman, I appreciate the opportunity to make this opening statement to the members of the committee and especially to our friends who are about to testify this morning. Thank you very much.

Mr. **Hall**. Thank you, Congressman. We are thankful to have you on the committee as well as on the Foreign Affairs Committee. I am sure it will be extremely helpful to the cause.

Let's proceed with testimony. Mr. Brady, if you could start off, then Mrs. Bruggemann, and then when Mr. Grant comes in, we will just go right down the line. After all the testimony, we will start with questions.

Mr. Brady.

STATEMENT OF NYLE BRADY, SENIOR ASSISTANT ADMINISTRATOR, BUREAU FOR SCIENCE AND TECHNOLOGY, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (U.S. A.I.D.)

Mr. **Brady**. Thank you, Mr. Chairman. I do have a statement I would like to present to the committee for the record. It is somewhat longer. I would like to take just a few moments to present a summary, if I could.

It is a pleasure to appear before this committee to testify on the role of the Agency for International Development (A.I.D.) in meeting the basic health needs of children and mothers. We believe that A.I.D. has charted an effective course toward the goal of improved health in the developing world.

To be sure, the number of children dying remains unacceptably high. Nevertheless, the prospects for survival of every child born in the developing world today are clearly better than they were even a few years ago.

We have put our money where our mouths are. From all sources, some $600 million have been committed for child survival activities from 1985 through 1988. We expect $1 billion to be committed through 1990.

Remarkable strides have been made in the name of child survival. Just as examples, measles vaccine for children under 1 year has increased from less than 20 percent coverage to more than 55 percent coverage since 1980. The use of oral rehydration therapy to treat diarrhea in children has increased from less than 1 percent to more than 25 percent of episodes. The availability of oral rehydration salts has increased to over 50 percent. The production of the salts has increased over 300 percent. Two-thirds are being produced in the developing countries, no longer having to be imported from the outside.

In Egypt, diarrheal mortality has been cut in half in less than 3 years using oral rehydration therapy. In Ecuador, there was a fourfold decrease in vaccine-preventable diseases.

The accomplishments of child survival are all the more remarkable in that they are the result of an international partnership that joins developed and developing countries, international and private organizations, educational institutions, individuals, and communities. It is to the credit of everyone involved, including my colleagues at this hearing, and, especially, the countries of the developing world, that so much has been accomplished.

We are proud that A.I.D. has contributed to these efforts. The 1980's has truly been a decade of achievement in child survival.

As we look to the 1990's, the first challenge will be to sustain the hard-won gains of the 1980's. There is no question but there are other pressing needs. However, we need to ensure that what has been accomplished can be sustained even as we attempt to accomplish more.

We need to recognize that many of the children at greatest risk have not been reached with critical services. Forty-five percent of children under 1 year of age are still not receiving measles vaccine. Three-quarters of the world's children under 5 are not using ORT and nearly one-half do not yet have access to the salts.

We recognize that the job has just begun. Sustainability was the focus of the Third International Conference on Oral Rehydration Therapy, ICORT III which was held in Washington last December. There were 500 participants from 50 countries who participated: ministers of health and finance, program planners and managers.

They were optimistic, but realistic. They identified several common themes. First, ORT programs ultimately depend upon families, on mothers and other care givers. They will respond if sensitized and educated and if appropriate therapy is available. Second, sustainable programs must be affordable by governments, communities, and families. Third, private sector involvement is essential for long-term sustainability. Fourth, oral rehydration therapy can revitalize and strengthen the entire health system; it can be the catalyst. Fifth, training is critical for mothers, community workers, and professionals. Sixth, evaluation and research are needed to identify successes and understand failures and to give us better tools.

Finally, a most critical factor is national commitment. As the Secretary of Health of the Philippines, Alfredo Bengzon, described the development of his country's national plan for diarrheal disease control and I quote,

> It may not be a perfect plan, but it is clear, courageous, and above all, it is ours: we made it, we approved it, and we are committed to it. In a sense, it is more than a plan. It is a statement of our will.

While child survival remains our primary focus in the health sector, we are not ignoring other opportunities such as helping to stem the spread of AIDS, improving health care financing, contributing to greater availability of water supply and sanitation, and improving maternal health care. In this regard we are pleased that this past year, we were able to begin a new central project signed to promote and improve maternal health. Our health sector programs also help to address tropical diseases, especially the resurgence of malaria. Finally, although we spend only a small portion of our funds on evaluation and research, such investments are key in making sure that we learn from experience and that inadequate technology does not constrain success. As a matter of fact, oral rehydration therapy was based on findings laid out in the field and then generalized and moved elsewhere. The same process applies to new strains of measles vaccine that can be given to youngsters as young as 6 months and still be effective. These are examples of practical products of A.I.D.-funded research that are being tested.

The challenges ahead are real and sobering. Donors and developing countries alike will face economic constraints and will need to make hard choices among programs competing for scarce resources.

We will need to find ways to engage the private sector, both voluntary and for profit, in the pursuit of better health. In this regard, the work of Rotary International's Polio Plus Program is an outstanding example of how the private sector can contribute on a large scale to child survival programs and how public finance can be multiplied many times over by private contributions and efforts.

The problems of the next decade will require resources. The economies of the developing countries must grow rapidly to provide resources for health and other important programs. The incomes of families must increase so that they can meet their needs. And, we must keep the resources that are available focused on areas that can bring the greatest benefit. We must resist the temptation to diversify and defocus our programs.

In closing, Mr. Chairman, I am pleased to announce that A.I.D. will release its fourth report to the Congress on its Child Survival Program tomorrow on the occasion of World Health Day.

In the foreword to this report, Administrator Allan Woods succinctly states our health strategy and I quote,

> The child survival program is a vital part of U.S. A.I.D.'s overall strategy for economic growth and development. Ensuring the health of today's children is the most basic of all investments in the physical and mental capacity of the next generation. Child survival has earned a rightful place on the development agenda.
>
> As we move forward into the 1990's, the challenge will be to sustain these gains and to consolidate a lasting foundation for the health of the world's children. U.S. A.I.D. has played an important role in these efforts. We are committed to continue this effort with the leadership and support of the U.S. Congress and the American people.

Thank you, Mr. Chairman.

[The information referred to above retained in committee files.]

[The prepared statement of Mr. Brady appears at the conclusion of the hearing, see p. 40.]

Mr. HALL. Thank you, Mr. Brady.

Mrs. Bruggemann. If I introduced you improperly, I am sorry. Mrs. Bruggemann is the representative of the director-general of the World Health Organization. Thank you for being here.

STATEMENT OF INGAR BRUGGEMANN, REPRESENTATIVE OF THE DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

Mrs. BRUGGEMANN. Thank you, Mr. Chairman. Yes, indeed, you introduced me correctly. Mr. Chairman, ladies and gentlemen, it is on behalf of the director-general of the World Health Organization, Dr. Hiroshi Nakajima, that I have great pleasure in conveying to you and all members of the Select Committee on Hunger his greetings and his appreciation for inviting WHO to present its views.

Dr. Nakajima regrets that he couldn't be with you personally today due to previous urgent commitments. However, he very much hopes that he will have an opportunity to be at one of your hearings in the future.

The scope and content of the issue under discussion "Improving Health of the Poor" is, of course, of crucial importance with its impact on health and the quality of life of millions of people worldwide.

As Congressman Bereuter already indicated, this is where the concern lies. We are talking about these millions out in the world and in more than one way, it is also one of the main preoccupations and priorities of the World Health Organization, its work, its mission over the past four decades and particularly so, in more recent years ever since WHO embarked upon what is popularly known as "Health for All by the Year 2000."

As you indicated, it might be a broad slogan, and yet, we can break it down into specific actions and I think this is what is at stake at this stage. You already referred to that tomorrow on the

7th of April, we celebrate World Health Day which will be observed all over the world, which gives special significance to this hearing. We appreciate the committee's decision to honor World Health Day by this discussion.

I indicated in the written statement that you have, briefly the world health situation. As Mr. Brady just said, Yes, there is progress. Yes, we do realize that we still have a long way to go.

In spite of the recognition that health is an integral part of development, we cannot deny that the health and quality of life gap between the developing and the industrialized world unfortunately is widening rather than narrowing. In spite of certain progress being made, there is still an unacceptable inequity in health.

Mr. Chairman, still today one-fifth of humanity—that means over 1 billion people—live below the poverty line and these people are mainly in rural areas and urban slums.

They are the victims of a vicious circle, a circle of unemployment, of under-employment, economic poverty, scarcity of household goods, low level of education, poor housing, lack of water, poor sanitation, and widespread malnutrition as well as prevalence of communicable diseases, all of which cause social apathy lead to the lack of will and the initiative to make changes for the better.

I am not referring in this context to the significant and acute emergency situations which often attract worldwide attention and I do not want to minimize their importance; I am referring to a permanent situation of deprivation to which the world remains very often oblivious.

We are aware and already certain data have been given on where we stand with this very crucial measurement, the infant mortality, and we do realize, yes, there is progress, and, yet, when we look at some of the extreme figures, we still are upset.

In 1987, at the worse end of the scale, there are still 217 babies dying out of 1,000 born in a country like Chad. These babies die before they have reached their first year of life while at the other scale of the spectrum, in the country like Sweden, this figure is as low as 7, only 7 per 1000 die.

The rate in Chad, therefore, is 30 times higher than that of Sweden and the average of the least developed countries still stands as 140 babies dying and only 12 in the 34 industrialized countries.

Yes, we know life expectancy has increased and, yet, the difference is still that in some parts of the world, it is only 48 years that you can expect to live while in others, on the average, it is 73. Yes, we do know that literacy rate is increasing and, yet, when we look at the figures so well explained in recent documentation by UNICEF, we do realize that women still are pretty low on the scale.

We do see that the relevance of women knowing how to read and write and the change in outlook on life is so crucial in its relationship to health. So, as long as these differences exist, Mr. Chairman, I think we are still far away from obtaining a universal social equity and with the lack of social equity, there will not be equity in health either.

May I take out of the list of health statistics the one element which shows the widest disparity in public health and that is, women dying during pregnancy or when giving birth to a child.

I intentionally avoided the rather clinical words of maternal mortality because I find that the tragic death of about 500,000 women, that is, 500,000 women who die every year from causes related to pregnancy and childbirth, are often discretely hidden behind this rather clinical way of saying maternal mortality.

It means women dying unnecessarily and I think that is what one has to understand in taking decisions which could change the fate of these women. Maternal mortality, in fact, is among the leading causes of death for women of childbearing age in most developing countries.

Of the total of these 500,000 deaths, all but 6,000 take place in developing countries which accounts for almost 99 percent of all maternal deaths. In the industrialized world, there are not more than ten women who risk their life when they give birth to a child, 10 out of the 100,000. This figure can range from 300 to more than 600 in the Third World.

Mr. Chairman, we are also aware that some major diseases still take a high toll of death, particularly in children under 5. Communicable disease, fueled by low standards of environmental sanitation, inadequate socioeconomic development and malnutrition, contribute to inordinately high levels of morbidity, mortality, and disability in developing countries, and they do effect particularly children under 5 years of age.

The mortality rate of children in the first 5 years of life ranges from 100 to 200 per 1000 live births in most developing countries. In the developing countries again, the incidence of vaccine-preventable diseases is still not low enough in order to avoid a significant effect on the morbidity and mortality caused by these diseases.

It is estimated that vaccine-preventable diseases of childhood still kill some 4 million children each year and cause disability in 4 million more. I am sure, in the statement by Mr. Grant, we will learn more about the positive results that have been achieved in fighting diarrheal diseases, in fighting acute respiratory infections which still are killers of children.

We seem to take it for granted that children have sniffs and coughs and yet these respiratory infections are still causing an enormous amount of death among the young child under 5. There is reappearance of diseases like malaria. It is estimated today that 56 percent of the world population lives in countries or areas where malaria continues to be a public health problem leading to about 220 million cases of malaria infections per year. This disease also kills children in Africa and the emergence of mosquitoes resistance makes it more and more difficult to fight this disease. As you know, one is looking for better available insecticides. One is trying to develop a vaccine, but we aren't there yet.

You have heard how in the past few years, the development policies of many countries have been dominated by structural adjustment programs made necessary by large debts in the servicing of those debts and Mr. Bereuter just referred to this issue which is in front of the Congress.

This has aggravated the world economy situation to an extent that there are clear indications now yes, indeed, it does affect health. The measures taken have stressed the maintenance of growth through devaluation, export promotion—I am not an expert and I should perhaps not talk about this—but as a result, government health budgets have contracted, sometimes dramatically.

In one African country, over a 5-year period, the health budget was reduced by 50 percent and another country, spending on health fell from 5 percent of total government spending to 1 percent.

We have indications that malnutrition is on the increase due to lack of resources. Yes, in fact, we have indications which we are studying right now, particularly in Latin America, that violence and suicide is increasing and seems to be immediately related to the present economic situation.

The effect on health of such decline is being seen in the reappearance of other diseases which directly relates to poverty, such as tuberculosis, yellow fever and yaws and, as I mentioned, malaria. In Africa, the percentage of hospital death from malnutrition has increased from fewer than 15 percent in 1976 to about 37 percent in 1987.

In another country, 87 percent of mothers were found to be giving their children only one or two meals a day during the weaning period because there wasn't enough food available, so the number of people living in absolute poverty is growing and it makes the health situation worse.

Mr. Chairman, I will not go now into further detail on the effects of endemic hunger and chronic malnutrition and yet, they are pertinent in the context of how and what to do in order to improve the situation.

I have briefly indicated that there is a major crisis in financing health, that we have to try and look into what countries spend on health and what can other countries afford in order to support these countries.

It was already pointed out that there is such a contrast between the funds that are spent on arms in relation to the investments made in the social sector. When you look at the comparison of GNP and public expenditure on health, again, on the extremes in the least developed countries, it is $4 per person per year, $4. While we in the developed countries can afford $690 on the average, $690 per person per year.

Already, it has been said, there has to be political will to overcome this. Political will is perhaps the most crucial point at this stage in order to eliminate the inequities in health and it needs education in order to make people understand how they each individually need to become part of the overall development for better health, how they have to influence their own health lifestyles in order to prevent diseases which are often man-made, and I guess I should be fair—they are not only man-made; I suppose they are women-made as well, in any case, diseases which we cause through our own behavior, diseases which we could call perhaps social diseases.

We eat too much, we drink too much, we smoke too much, the whole crucial issue of drug addiction, the over-driving, if I can call it that—less in this country, but in Europe, it is still the car that gives the power, so the increasing number of accidents—careless behavior, careless behavior also leading to a new scourge, AIDS.

So, we have to realize that the problems we are discussing are not necessarily only problems of the Third World. I realize that this committee is concerned with the Third World and yet, we, I suppose, are aware how these problems we have indicated do exist in certain pockets in almost any population in any given country.

Yet, we are aware that fighting these problems is the right of everyone. WHO has declared in its constitution that health is a basic human right of all people and so, I would only like to confirm again that, yes, health is a cornerstone in development; yes, health has been realized in its immediate impact on development issues.

So, the mandate that was already cited at the beginning of this hearing, that is to look for "Health for All by the Year 2000" and beyond is the objective that we are all looking for. I shall not go into detail about how the forefathers of WHO, including the United States at the time, when writing the Constitution, had the wisdom of not speaking about the diseases one was fighting after the Second World War, but looking for improved health conditions in general, which has given us an agenda which will take us well into the year 2000 and beyond.

As already mentioned, in Alma-Ata UNICEF and WHO's members states that took part in the conference decided on making primary health care the vehicle to arrive at a better and improved health.

The first principle of primary health care is to have access to information on health. The next one concerns food and nutrition, with strong emphasis on the availability of food, before you even think about nutritional determinants. If the food is not available, all academic talk about nutrition doesn't help much.

The third one concerns safe water and sanitation. If we realize that even today women have to walk for 3 hours per day to look for water. If such a basic condition for health is not available, we are far from having access to health.

Maternal and child health care was given prominent position in primary health care, including family planning and this means trained personnel for attending women during pregnancies and childbirth and caring for children up to at least 1 year of age. It is today in Africa that still only 34 percent of women have such an attendance and are taken care of. Another element is the immunization of which you have already heard. The next is the prevention and control of at least those diseases that exist locally—to have at least a minimum of treatment available. It should be at least in reach within 1 hour's travel or walk. Availability of essential drugs.

I would have liked to speak more about the progress achieved, but I realize that time is short and I have tried to explain this in more detail in the written statement which is in front of you. Let me point out some of the problems that still exist which need to be overcome.

We still have a high population growth. We still have too low female literacy. We still have to face the problem of growing urbanization with all its consequences for health. We have the enormous economic constraints and deterioration of the socioeconomic conditions in many developing countries which put a risk to all the progress being made so far.

We have weak management of resources and we have the inadequate application of what we already known, the inadequate application of science and technology and the lack of using appropriate technology, which has been developed, at low cost.

Mr. Chairman, may it suffice at this stage to once again express the sincere thanks of the World Health Organization for the support it has received from this very government, from its scientists, from its health institutions, from its nongovernmental organizations over the four decades of the existence of WHO.

We are fully aware that only in collaboration both within and outside the United Nation's system, as exemplified between UNICEF and WHO and many other agencies and the governments concerned will there be progress in health, including the combat against AIDS, a problem which appeared after having started the march for Health for All in the Early 1980's.

Let me summarize, WHO will pursue its mandate of improving access to a better health for everyone through primary health care. It recognizes the new challenges that have emerged since Alma-Ata, the problems of AIDS, the increasing environmental hazards, the declining resources for health care and the research needs for improved appropriate technologies.

It is recognized that health as development cornerstone requires long-term, constant national and international support. To seek and maintain equity in health, governments, bilateral and multilateral aid agencies, nongovernmental organizations and the private sector need to cooperate and coordinate their support to national plans and programs.

Health development requires world solidarity, it requires political commitment and the involvement of individuals, communities and, as I said, the nongovernmental organization and private sector. The support in the context of improving health of the poor is required to fight infant mortality, malnutrition, high child mortality under 5, and mothers dying in childbirth. Practical solutions are at hand. It calls for support of an unprecedented scale.

Mr. Chairman, my final thought is related to the work and concern of your committee. In the perspective of global health issues that I have tried to briefly outline, we believe that the health for all strategies and programs derived from them as well as the child survival and development activities and the additional challenges which I mentioned have taken deep roots in almost all the countries of WHO's member states.

Apart from the developing countries who are the main focus for the fundamental thrust of these strategies, also industrialized countries have greatly benefited by appropriate adaptation of the primary health care approach leading to their health promotion initiatives which are based on very specific targets.

In the context of these positive developments, it is more than ever necessary for your committee to sustain its support and I appreciate very much the initiative taken with the draft resolution by your committee, for the U.S. Congress and the U.S. administration to yet further strengthen their role and leadership in international health cooperation.

Such a process in practical terms will mean working with multilateral developmental institutions and organizations such as UNICEF and WHO to accelerate on the one hand formulation of rational health policies and programs and enhancing through U.S. A.I.D. and other partners the translation of these technical cooperative programs in key areas of health development.

Indeed, we see no other short cuts to these complex problems. Mr. Chairman, the director-general has asked me to reassure you that WHO stands ready to work with you towards this end.

I thank you, Mr. Chairman.

[The prepared statement of Mrs. Bruggemann appears at the conclusion of the hearing, see p. 62.]

Mr. **Hall**. Thank you, Mrs. Bruggemann. I want to welcome to the committee Congressman Dorgan, Congressman Payne, and Congressman Foglietta, and ask them if they have any comments or any written statements. Thank you.

I also want to welcome to the first panel our good friend, Jim Grant, executive director of UNICEF; glad to have you back again. We understand that your statement is for our information only and we respect your role as a key international civil servant.

We are so very glad to have your goodwill ambassador, Ms. Audrey Hepburn, with us. Thank you so very much. I didn't know how you wanted to proceed, if you have a statement, if Ms. Hepburn wanted to go first or you, Mr. Grant.

Mr. **Grant**. Why don't I let the lady say a few words first.

Ms. **Hepburn**. You're the boss.

Mr. **Hall**. Why don't we start off with Ms. Hepburn. We are so very glad to have you and certainly your commitment to this issue brings something very important in having you be able to go all over the world and speak. So, we are so very glad to have you join this very important cause. Ms. Hepburn.

STATEMENT OF AUDREY HEPBURN, VOLUNTEER, UNICEF, ACCOMPANIED BY LAWRENCE BRUCE, PRESIDENT, U.S. COMMITTEE FOR UNICEF

Ms. **Hepburn**. Mr. Chairman and distinguished members of the select committee, thank you for the opportunity to appear before one of UNICEF's and Child Survival Program's strongest friends. I am accompanied today by Lawrence Bruce, the president of the U.S. Committee for UNICEF. We travelled to Ethiopia together last year.

I would like to say at the outset that we are all deeply grateful to the Select Committee on Hunger and its International Task Force for your leadership and efforts in support of UNICEF and the Child Survival Program.

Your trust and support have provided UNICEF and their partners in the field the fuel and encouragement to succeed against great odds. Up until a year ago before I was given the great privilege of becoming a volunteer for UNICEF, I used to be overwhelmed by sense of desperation and helplessness when watching television or reading about the indescribable misery of the developing world's children and their mothers where 60 percent of the population of most countries live below the poverty line and by that I mean no water, no sanitation, no electricity, no primary health care, no education.

If I feel less helpless today, it is because I have seen what can be done and what is being done by UNICEF, by many other organizations and agencies, by the churches, by governments, and most of all, by the people themselves.

I have travelled thousands of miles on large and small planes and hercules and helicopters to visit rural and isolated areas which, but for UNICEF would still be forgotten and neglected as they have been for centuries.

In Ethiopia, I saw a dam being built by thousands of men, women, and children carrying rocks on their backs, a UNICEF Food for Work Project. Agricultural centers in the most arid drought stricken areas of Ethiopia where vegetables and trees were growing, thanks to a well dug with the assistance of UNICEF, where cattle had died in the drought were replaced by UNICEF and are now grazing on grass, the seeds through which had been provided by UNICEF.

These communities needed no emergency help in the last drought, a clear illustration that drought need not mean famine. I went to the orphanage in Mecalee of 500 children whose parents died in the drought of 1985 and which is run by Father Chasade of the Catholic Church.

It was he who in 1985 in desperation said, "If you can't send me food for my children, then send me the spades to dig their graves." Ever since, UNICEF provided him with supplementary foods for his children.

In Latin America, I have seen tiny mountain communities, slums, and shantytowns receive water systems for the first time by some miracle and the miracle is UNICEF. I have watched boys building their own schoolhouse with bricks and cement provided by UNICEF.

In Latin American, an average of 50 percent of the population is illiterate. I have witnessed people teaching themselves how to read and write in the open air with the tree for their classroom, listening to one small transistor radio which broadcast literacy programs implemented by the Catholic Church, supported by UNICEF.

Then, there are the UNICEF assisted open houses for street children who instead of being institutionalized can come and go freely, be fed, sleep, wash, receive lessons, and are protected and respected.

I was in El Salvador when they were preparing for their day of tranquility, the yearly truce negotiated by UNICEF when two factions in disagreement agreed to lay down their arms long enough to vaccine their children.

I have visited many, many day care and health care centers which are vaccinated and monitored. There is one thing all these countries have in common, the extraordinary resourcefulness of the people. Their courage, their faith, their cheer, is an experience I shall never forget.

The effects of the monstrous burden of debt has made the poor even poorer and has fallen most heavily on the neediest and those whom which it has damaged the most have been the women and the children. Children cannot wait; they are too fragile to wait for an economic crisis to pass.

We, therefore, cannot wait to do more about the alarming state in which the children in the developing world are only just surviving, especially when we know that the finances needed are minimal compared to the global expenditure of this world, when we know that less than one-half of 1 percent of today's world economy would be the total required to allocate the worst aspects of poverty and would meet basic human needs over the next 10 years.

The question I am most frequently asked is, "what do you really do for UNICEF?" Clearly, my task is to inform, to create an awareness of the needs of children and to fully understand the problems of the state of the world's children, it would be nice to be an expert on education, economics, politics, religions, traditions, and culturals.

I am none of these things, but I am a mother and unhappily, there is a need for great advocacy for children, children haunted by undernourishment, disease, and death and you don't have to be a financial whiz to look into so many little faces with glazed diseased eyes to know that this is the result of critical malnutrition, one of the worst symptoms of which is vitamin A deficiency that causes cornea lesions resulting in partial or total blindness, following within a few weeks by death.

Every year, there are as many as 500,000 such cases in countries like Indonesia, Bangladesh, India, the Philippines, and Ethiopia. Today, there are, in fact, 200 million children at risk of going blind. Many of the UNICEF volunteers travel the world to raise funds before it is too late, but also to raise awareness and to combat a different kind of darkness, the darkness people find themselves in through lack of information.

Oh, how easy it is to reach out and help these children. It costs 4 cents a year to stop a child from going blind, the price of two vitamin A capsules. I have known UNICEF a long time. For almost 45 years ago, I was one of the tens of thousands of starving children in war-ravaged Europe to receive aid from UNICEF immediately after our liberation, a liberation that freed us from hunger, repression, and constant violence.

We were reduced to near total poverty as is the developing world today for it is poverty that is at the root of all their suffering. The not-having, not having the means to help themselves and that is what UNICEF is all about, helping people to help themselves, giving them the aid to develop there by allowing them to become self-sufficient and live in dignity.

UNICEF's business is children, not the workings of the international economy. It is everyday work in over 100 developing nations. UNICEF is brought up against the face of today's internationally economic problems which is not seen in the corridors of financial power, not reflected in the statistics of debt service ratios, not seated at the conference tables of that negotiation, it is in the face of the child.

It is the young child whose growing mind and body is susceptible to permanent damage from even temporary deprivation, the human brain and body are formed within the first 5 years of life and there is no second chance.

It is the young child whose individual development today and whose social contribution tomorrow are being shaped by the economics of now. It is the young child who is paying the highest of all prices. We cannot, therefore, ignore the economic issues for so many millions of the world's poorest families have made the 1980's into decade of despair.

Three years ago, Tanzania's president, Julius Narerea asked the question, "Must we starve our children to pay our debts?" Today, there the heaviest burden of a decade of frenzy borrowing is falling not on the military or on those foreign bank accounts or on those who can see the years of waste, but on the poor who are having to do without the bare necessities.

On the women who do not have enough food to maintain their health, on the infants whose minds and bodies are being stunted because of untreated illnesses and malnutrition and on children who are being denied their only opportunity ever to go to school.

When the impact becomes visible in rising death rates among children, then what has happened is simply an outrage against the large section of humanity. So, Mr. Chairman, I am here today to speak for children who cannot speak for themselves, children who are going blind through lack of vitamins, children who are slowly are being mutilated by polio, children who are wasting away in so many ways through lack of water, for the estimated 100 million street children in the world who have no choice but to leave home in order to survive, for children who have no enemies, but are invariably the first tiny victims of war, wars that are no longer confined to the battlefield, but which are being waged through terror and intimidation and massacre, children who are, therefore, growing up surrounding by the horrors of violence, for the hundreds of thousands of children that are refugees.

In the last few weeks, 20,000 starving orphan boys have fled from the Sudan into Ethiopia. Many of these boys never make it to safety. They either die of hunger on the way. It sometimes takes them months of walking to reach the destination or they drown in the river which divides the Sudan from Ethiopia.

This has created a heartbreaking phenomenon never seen before, a camp full of small boys. There, too, UNICEF is present. The task that lies ahead for UNICEF is ever greater, were it be repatriating millions of children in Afghanistan or teaching children how to play who have only learned how to kill.

UNICEF is almost valuable arm against suffering in the developing world, a truly effective arm for peace. UNICEF has the international organization and infrastructure and the diplomatic leverage to channel aid directly to children and not through governments, but together with the governments, NGO's and other admirable agencies bring relief at the grassroots.

They may not be able to resolve the debt problem, but they can help hundreds of millions of people in the developing world to become healthy, productive and largely self-sufficient. It is possible to end the worst manifestations of poverty. I pray that the lifeline that UNICEF represents and which you have always go generously help maintain need not be diminished.

Every child has the right to health, tenderness, to life. Thank you, Mr. Chairman.

Mr. **Hall**. We thank you for your personal testimony and your travels in the effort and we appreciate your lending that wonderful name to efforts to relieve the plight of the children of the world.

Mr. Grant, I think what we will do is go to you and then we would like to ask some questions of the panel. I am not sure what Ms. Hepburn's schedule is. If she can stay for a couple of questions, we would appreciate that too.

Jim, it is good to have you with us. Please proceed.

STATEMENT OF JAMES P. GRANT, EXECUTIVE DIRECTOR, UNICEF, ACCOMPANIED BY AUDREY HEPBURN

Mr. **Grant**. Thank you very much, Mr. Chairman, distinguished members. It is a great pleasure to be back with you again. You are a supportive and leadership body that have made a very significant difference to the world's approach to hunger, to the condition of the world's children.

I returned late last evening from Africa and it was a very heartwarming thing to see your fellow committee members, including Congressman Leland, in action in the field.

We were together along with Julia Taft in the Sudan and in Addis Ababa and in Nairobi where everything was focused on this terrible disaster in the Sudan. It really was a marvelous example of one plus one plus one, not only being five, but maybe 12 or 15 as we dealt together with heads of state or the heads of the SPLA, the rebel movement, communicating the same message from different vantage points. That made a tremendous difference.

On this subject of partnership and collaboration, we have just heard a vigorous statement from Audrey Hepburn, one of the volunteer partners of UNICEF. I should take this opportunity to stress that we are in the presence of many others partners here and that in coping with these problems, it is not only the committee that has played an important role, but that it is WHO, and U.S. A.I.D.

I see behind me Herbert Pigman of Rotary International which has played such a dynamic role on the polio front; also Bill Foege who has been the executive secretary director of the Task Force on Child Survival that has brought international governmental and private agencies together to work on this.

It has been, I think, one of the most rewarding aspects of the past several years, to see this emerging grand alliance for children which, though still very much a minority is making itself felt in a much greater way. If I may say, Mr. Chairman, I have a longer statement here, if I may put it in the record.

I just got back last night. They did not have a chance to run it off this morning as I came in, but let me just highlight, if I may, four or five points by starting out first to say that the statements that I have heard from my colleagues really represent what we in UNICEF believe in too.

We are collectively working on this task. UNICEF puts out late in December each year its annual State of the World's Children. Most of you are aware of it. Copies of available to the members of the committee. This year we emphasize very much the witches brew of the economic crisis that is affecting so much of the developing world, particularly Latin America and Africa, and which has been referred to by all three of the prior witnesses.

It is absolutely clear that particularly in Africa and Latin America, without a resolution of what is now come to head in the debt crisis that it will be impossible to sustain major progress for children in the decades ahead and in that sense, we welcome very much the actions of Secretary Brady in coming through with a start to a new approach, but it is very clear that this—we would hope that this would be approached with a sense of urgency.

We say in the State of the World's Children that over 500,000 children died last year as a consequence of the economic crises in these two continents, over 1,000 a day in Africa, 500 a day in Latin America, so time is of the essence.

The second message which is the one you have been hearing from our colleagues here is that there really is a greater potential for forward movement on the health of children than at any time in history. There is this potential breakthrough for children.

Some problems for children are difficult, they're intractable, they are going to take a great deal of work. Drugs, street children, these are hard problems. We don't have the answers, but there are a whole series of problems of children for which what needs to be done no longer is in question.

We know what needs to be done, we know what can be done at very low cost. We know the dramatic results that can be achieved. This was really dramatized by Dr. Nakajima, the director-general of WHO, last fall when in Houston he said,

> We must recognize that most of the world's major health problems and premature deaths are preventable by changes in human behavior at low cost.
>
> We have the know how in technology, but it must be transformed into effective action at the community level. Parents and families properly supported * * *.

He went on to say,

> * * * could save two-thirds of the 14 million children who die every year if only they were properly informed.
>
> Immunization alone could save 3 million lives and another 3 million deaths a year could be prevented by oral rehydration, a simple and cheap technology.

Now, what you and this committee have helped us do in the last several years is to put a focus on this and on the fact that these diseases are a principle cost of malnutrition as well as being diseases in their own right. You have helped us put the focus and action on these.

This has enabled us to say in our report this year that WHO and UNICEF together now see some 1½ million children not dying of these immunizible diseases as a result of recent accelerated actions. Nearly 1 million children are not dying of the dehydration from diarrhea because of these recent accelerated actions.

We are at the point where we could anticipate doubling these numbers, these 7,000 children that are being saved a day now to 12–14,000 within 2 years—if the additional will is there. Cost is not the major factor. We could see doubling it again in the 1990's if the will is there. Equally encouraging is the fact that we are finding that these family involving methods of reducing child mortality have a very powerful impact on attitude on family size.

We can predict, based on past performance, that if the Child Survival Revolution succeeds, there would be an even greater reduction in the number of births each year as a consequence of the use of these self-health techniques that involve the family itself.

So, this is a very encouraging aspect, but at the heart of it remains still the question of will. The debt crisis, the economic crisis has hurt children in two ways: First is the adverse impact of the national economic crisis. Second is the tendency of countries as they adjust to the crisis to place an undue share of the burden on the most vulnerable and politically least powerful sector of society. The impact has been worst on children and mothers. What we have been doing in the primary health care, child survival and development revolution front has been to say to governments, "You can restructure the health sector as long as you protect it with money, you can make that health sector vastly more effective than it was before, but it takes political will."

In virtually every country today mass immunization is possible, in place is the cold-chain, the vaccines, the vaccinators, the whole system is in place in virtually every country in the world: China, India, Ethiopia, and Nigeria.

What is still lacking is the social mobilization to make sure that the mothers come in and use it and that the ones who come in once, come in the second and the third time. We must make the governors, the village chiefs, take on that feeling of responsibility.

How do we get television and radio to do even more education than they are doing? I must say that as I travel through Africa, I have been in nine African countries in the past 5 weeks, it has been interesting to note that in this one field, they are mobilizing.

In eight of those countries, it is now a topic for consideration at the cabinet level where, once a month, they look at the situation in each province to see what is happening, where the lag is as they approach the 1990 deadline.

On the question of political will, a very important development in the last 12 months has been the fact that not only do we get more national leaders active in these child health programs, but it has become a matter of summitry, so that the Organization of African Unity with 31 heads of state present when it met last May, made children the special topic before them and they acted with rather strong resolutions.

It is noteworthy that when Mr. Gorbachev and Mr. Reagan met in Moscow, the one nonsecurity issue taken up was the health breakthrough now in process for children. They both stated that they would provide increased support for this breakthrough, through WHO and UNICEF and called on others to do the same. Interestingly enough, it has proven not just to be words.

Mr. Gorbachev subsequently wrote both to WHO and to UNICEF and we have had a 12-fold increase in the rather modest contribution that the Russians have been giving us to date. A 12-fold increase for this year and the promise of increased contributions yet to come.

So, when we get to this question of will, it clearly needs to come from every side. It needs to come from the Rotarians. We need the media to dramatize what can be done, but we also need the will from the people at the top. In our State of the World's Children, there was the proposal for a world summit for children, one that struck many people as being rather odd at the first blush. A world summit?

You mean you get the Gorbachevs and the Bushes and the Ghandis and the Deng Xiaoping together just to talk about children? On the other hand, we do have 40,000 children dying every day and the preventable parts of this, the readily preventable parts of this exceed in an Armenian disaster each day.

That is the number of deaths that could be prevented just through oral rehydration therapy, immunization, increased breast feeding—the noncostly part of it. To date, some 22 heads of state have come out in support of this. The International Parliamentary Union has come out at its meeting in Budapest with some 500 odd members of Parliament from 98 countries supporting a summit.

I have noticed, Mr. Hall, the resolution that you and others are putting forward in this area and I myself, if I may speak now as an American, would say, "I would be proud if the U.S. Congress would once again——" it was the U.S. Congress which was the first in the Child Survival Revolution to pass, of all the parliaments in the world, a resolution on this, "If you would take the lead in encouraging the President of the United States to take an active part in this and maybe even a leading role in the convening of such a meeting."

Two other things I should mention very briefly. One is that in the last year there has been much progress on this concept of a Convention on the Rights of the Child, which includes the right of the child to survive, the right of a child to be protected against abuse, the right of a child to develop through basic education, and it now looks as if this convention will be adopted by the General Assembly of the United Nations this fall.

It will then have to come up for ratification, but this in itself is a miracle to have come this far. There are more than 50 countries in the world today in which children are caught in a conflict situation, this represents a dramatic change since World War I.

At the time of World War I, less than 10 percent of the casualties were civilians. By World War II the number was 50 percent. Currently 80 percent of casualties are civilian. And in the kind of conflicts we see in Southern Africa and in the Sudan, the figure reaches over 90 percent. The majority of these deaths are children.

It was my privilege the day before yesterday in Harare to release UNICEF's second report entitled Children on the Front Line documenting the situation of children in Southern Africa and the impact of the conflict over apartheid that is taking place there. Since 1980, something like 1.3 million people have died as a direct result of that conflict.

Over 850,000 of these deaths were children. In the last year, roughly 150,000 children died in Angola and Mozambique alone as a by-product of the turmoil that has erupted over the issues of apartheid in Southern Africa.

As I mentioned, last weekend, and most this past week has been spent dealing with the Sudan. There again, we have seen a situation where last year strictly because of the civil war, 250,000 people died, the majority of them were children.

They died in considerable part because the media of the world, the public opinion of the world, couldn't gain access to them. Both sides, frankly, were disregarding the lives of the civilians caught in the middle. It was only last fall and winter, as pictures began to trickle out and the scale and the disaster became apparent, that world public opinion began to react and the Congresses of the world, the Congress of the United States, began asking the governments of the world what is happening? Why not? When are we going to act?

With this increasing attention that has been rapidly rising in the last 2 or 3 months, we are now in a position to, I think, possibly, pull off a miracle and avoid a repetition of this disaster.

As you know, the dilemma in the south is that once the rains come in the middle of May, transportation becomes impossible. The challenge for us is how, in the 6 weeks that remain, to move some 120 tons of goods into the most remote area of the world, with the weakest transportation links of the world, with a civil war on. It will take a miracle to succeed.

I think we can succeed, but at the heart of whether we succeed or not, is public opinion. This brings us back to the question of will. We know frankly that the world can lick hunger today. It really is the lack of will. It isn't the question of funding anymore.

In the Sudan question, it is the public opinion that is going to keep the pressure on the two sides to allow the supplies to move. At the same time, of course, we need the support that comes from governments to do this. Ms. Hepburn will be going to Sudan next week. We have arranged a month of tranquility and the object is to dramatize it and to keep the world public attention on it.

The work that this committee has done to keep the eyes of the world on the hunger problem and to keep the eyes of the world on the fact that most aspects of disease and hunger can be coped with within reasonable means, has been inestimable value. And the legislation that has been introduced in the U.S. Congress thanks to the work of this committee has had an affect not only on what the United States has done, but has also positively affected the attitudes of many other countries and of beneficiaries of it who have been emboldened to take on more vigorous actions. Thank you, sir.

[The prepared statement of Mr. Grant appears at the conclusion of the hearing, see p. 83.]

Mr. HALL. Thank you, Mr. Grant. We want to thank all the witnesses for their testimony and for their tremendous work in this area. Mr. Grant, you said one of the biggest challenges that we have is, educating women to come back a second and third time after they have been immunized, taught about basic breastfeeding, and ORT. Not only is it a challenge to educate them, but the other challenge, it seems to me, is educating the people of the world that have the ability to help, once the media stops focusing on the issue. There has to be a major catastrophe like Sudan or Ethiopia, for the media to focus.

There is still going to be UNICEF and there is still going to be the World Health Organization and A.I.D., but we need more workers. We need development programs. We have made tremendous progress. It seems to me what we need is a lot more education of our own people as well as the people in the field, but how do you feel about that?

What is our real challenge in this area? How do we handle this?

Mr. GRANT. Well, there is at the heart of it all is motivation, education, and the great blessing that we have today is that there are channels of communication that really didn't exist before. So not only do we have technology that is very helpful like the new vaccines, the oral rehydration packets that we carry around with us, but we have the new capacity to talk to people. It is quite true that when television picks up a picture in the Sudan and says, when Ms. Hepburn is there next week, these children are dying and there is still time to do something about it. People react differently than if—as really happened this last fall—the media weren't able to get in there. Then you saw only the bodies of the dead 4 months later and you could see how bad it was. We have the need on the one hand, I think, to educate our own people as to the tremendous opportunities that exist to change the world around us.

Our difficulty is frequently how to get the media to help us do this on the silent emergencies. On the hunger/malnutrition/disease front, the equivalent of an Armenian died yesterday. Now, if you had an Armenian tomorrow, all the media would be on it, but they haven't yet been sufficiently helpful to us in doing the educational work on building up the motivation to prevent the needless deaths of 40,000 children each day.

It is growing, however, and that is the kind of work that we get out of—let me come back to what the present witness—the Rotary International; going back to every Rotary chapter and doing this kind of education work.

The kind of work that the Children's Defense Fund is doing here in this country is very powerful. In educating the people who need to know, the opportunities and channels for us are endless. I think to me one of the favorite examples is in Brazil where there has been a massive move away from breastfeeding. We have been looking for ways to shift that.

A television spot, 15 seconds, featuring the world's most popular football star, a man by the name of Pelé is an example. He appears on television with his mother and she has her arm around him—15 seconds—she looks up at him and says, "Of course, he was a breastfed baby."

Now, that is a very powerful communicator to the fathers and the mothers and everybody else in Brazil. Our challenge is, how do you get the television to give us the time, how do you get the Pelés of this world, the Audrey Hepburns of this world, to participate in this effort? I think we are making substantial progress on this, but this is really why we talked about the possibilities of a world summit, because it is what important people say that help other people decide what is important.

Now, it is equally true as we have discovered in the abolition of slavery and then colonialism and now in protection of the environment that what a small minority insists on and pushes can gradually make it good politics for governments to act and bad politics not to act. One can get a tremendous boost at the right time from the heads of state moving and this is why it has been our feeling that if a world summit were to take place, this would contribute tremendously to the educative factor. The summit could focus on just three things.

One is that needless deaths and malnutrition are taking place today—equal to an Armenia—and if we will just focus on it, within 5 to 10 years it can be overcome. We can eradicate polio and eradicate a series of other health problems.

Achieving this is 90 percent will today and only 10 percent money and new technology. A summit could dramatize the fact that we have a Convention on the Rights of the Child that is coming to fruition. This would make families of the world treat children as important, and, most importantly, governments. If you take most countries, a majority of countries, when push comes to shove, children and mothers still come toward the end of the line. The convention is an important method of changing some of that attitude.

Finally, such a summit would not solve the debt problem, but it is going to say, when there is restructuring to deal with the debt problem, there should be adjustment with a human face.

I would hope it would also say that in the next 10 years as we look forward in industrial countries as well as developing countries, that children ought to be moved to the front. We must avoid the situation where we have even had the United States in the 1980's with reasonable degree of prosperity in this period. In the United States the bottom third of children are worse off today than they were 10 years ago. What we are learning is that it takes only a shift in attitude and will. I close on this point. What happened in UK in World War II when the war started and 50 percent of the gross national product of the Great Britain marched off to war?

They took the conscious decision, we are fighting for a future for our children. That is what we are dying for and we are going to see to it that in this war, our children don't bear the primary burden of the reallocation of resources to war. At the end of World War II, the health of children and of pregnant mothers was substantially higher than it was at the beginning of the war. I think this is a dramatic illustration as we look at the next 10 years ahead of what political will can do and the kind of contribution that comes from committees like this.

Mr. HALL. I would like for Ms. Hepburn to react to that same question if you have anything to add, but I also understand that you may have to leave here within the next minute.

So, could you react to that question?

Ms. HEPBURN. Well, Mr. Grant gave such a full answer, I think there is very little I can add to it. I think part of your question earlier was also about having enough actually helpers in the field and UNICEF has strained—I don't know, something like 65,000 helpers for health clinics and so forth. So, it is a constant action, but everything must be more today than what we did before because of the debt crisis, the misery has really augmented so alarmingly that that is what we need.

We will need more healthcare, more helpers, more funds.

Mr. HALL. I am going to let Ms. Hepburn go now unless any of you have a question.

Mr. GILMAN. No, just, Mr. Chairman, I would like to commend to Ms. Hepburn—Mr. Grant said we need more Ms. Hepburns out and

I would hope that she could reach out to the entertainment community and get more of our popular figures involved in this very important effort.

Ms. HEPBURN. Thank you for saying that, but, you know, I don't think I need to reach out to the entertainment community. I am very proud of my colleagues, starting with Bob Galeoff. I mean, so many of them do so much really in many areas whether it is with human rights, whether it is for children or whether it is for the developing world or AIDS.

I think they are doing a pretty fabulous job.

Mr. GILMAN. We thank you for your work.

Ms. HEPBURN. Thank you so much.

Mr. HALL. Congressman Payne—do you have a statement?

Mr. PAYNE. I would just also like to thank Ms. Hepburn for the tremendous work that. Just quickly, it is good to see you and I hope that the trip to Sudan will produce the same amount of coverage that your trip to Ethiopia did last year, but I think more importantly, that you remember an organization that was helpful to you many years ago.

If more people around the world could appreciate organizations and people who help them, I think we would in a much better state than we are in today and so, I would just like to thank you also for your tremendous work.

Ms. HEPBURN. Thank you very much.

Mr. FALEOMAVAEGA. Mr. Chairman, I also would like to briefly express my appreciation for Ms. Hepburn's participation in our panel discussion this morning. This is certainly a distinguished honor and privilege for me to meet someone of her stature.

After watching the ever popular "My Fair Lady" movie, at least this member certainly appreciates the tremendous talent that she has displayed in her special area, but at the same time, I hope she will continue her work and I am sure that along with my colleagues, I extend to her our blessings and best wishes for her fantastic work on behalf of the young people in the world.

Ms. HEPBURN. Thank you very much.

Mr. HALL. Thank you, Ms. Hepburn. We wish we could keep you a little bit longer, but we know that you have to go. Thank you very much. We have other questions of Mr. Grant, Mr. Brady, and Mrs. Bruggemann.

Mr. Gilman, would you like to——

Ms. HEPBURN. Goodbye, Mr. Chairman; goodbye gentleman. I thank you very much.

Mr. HALL. Thank you.

Mr. GILMAN. Thank you, Mr. Chairman, for permitting me to go out of turn and I regret I was late and I have to go on to another meeting. I want to commend our distinguished chairman of our International Task Force, gentleman from Ohio, Mr. Hall for bringing us together on this very critical issue.

I commend our ranking minority, the gentleman from Nebraska, Mr. Bereuter, for his leadership in the House Foreign Affairs Committee and the Banking Committee in regard to the child survival issues and the impact of the world debt on those issues.

He has recently introduced resolution which will put the House on record in support—put the House on record in support of actions to eliminate preventable deaths and disabling illnesses especially among the world's children, gives, I think, a chronology of the issue and provides a sound direction for all of us in working on this issue, so I am pleased to join with him in supporting the call for a world summit on children, something, Mr. Grant, pointed out in his testimony and I hope we can do that at the earliest opportunity and I look forward to being able to provide further support on this issue.

I would like to comment Mr. Grant who has been a long time veteran on this issue, this very critical issue, and we welcomed his initiatives and his direction and I commend him too on the publication of "Children on the Front Line" something that I look forward to reviewing and commend the United Nations Children's Fund for publishing it at this appropriate time.

I wanted to take, too, this opportunity to express our appreciation for the great work that World Rotary has done. I have seen some of that right in my own congressional district as I watched them bring together funding for this issue and bringing the issue at home to the smaller communities.

You say that the intent, the will is so important and I think Rotary International has helped to bring that intent together by educating our communities with regard to the critical nature of this problem and when Mr. Grant talks about all we need is the will, I am reminded of when Harry Chapin brought us together to help and John Denver to help us start the Presidential Commission on World Hunger and Mr. Grant appeared before us on a number of occasions.

As a matter of fact, the work of that commission helped us to create this very committee, this Select Committee on Hunger which was a recommendation of the Presidential Commission on Hunger during the Carter years, but, again, we in all of our testimony and all of the material and people who came before us, we were convinced that we had the ability to resolve world hunger and all we needed there was the will of various communities, very sovereignties of the world to do it and we could accomplish resolving world hunger within the foreseeable future, just as we can overcome the problem of child survival.

One question I do have of Mr. Grant, you talked about a $55 million fund campaign that you are about to embark on, where do you anticipate those funds will be coming from and what can Congress do to be of assistance to you in that direction?

Mr. GRANT. This is the $55 million required for the Sudan, Operation Lifeline Sudan, that is the one figure I believe you are referring to. We are at the moment looking to both governmental and private sources to provide this. I should say on this that the U.S. A.I.D. has been very much in the forefront in this and I for one have been very proud.

Now, I am going back to my role as an American citizen to speak of the way that U.S. A.I.D. has participated and helped lead in this particular area. There obviously has been a very close interaction between Congress and U.S. A.I.D. on this. I think Congress in a sense set the first pressure and then U.S. A.I.D. acted.

This may sound rare from my point of view—I would say at this moment that U.S. A.I.D. is making a fair contribution to Operation

Lifeline Sudan. What I have been doing recently is been trying to tell the other countries that it is up to them to respond proportionally.

For example, we have had nongovernmental organizations from France, from the UK, come to the United States for funding and I have gone back to both governments and said to them, "Look, you ought to be ashamed of yourselves. Medicines Sans Frontieres-France ought to be funded in Europe, not out of Washington, Save the Children in the UK ought to be funded out of the UK," and I am pleased to note that both in both cases, funding is becoming available and just yesterday, when I was in the UK on my way back, the minister Chris Patten of overseas development announced two 2 million pound contributions to UK NGO's working in the Sudan. This was in response to the kind of funding leadership taking place here.

So, you see me in a rare situation of not pushing for more funds per se at this moment from the United States on this, but obviously, you have to replenish it for the next round.

Mr. GILMAN. Again, I want to thank you, Mr. Grant, for the great work you have been doing over the years and we hope you will continue to do it for a long time to come. I regret that I have to go on to another meeting. Thank you, Mr. Chairman.

Mr. HALL. Mr. Brady, I am very appreciate of work that A.I.D. has done in the Child Survival Program over the last few years. I do have to point out though that funding levels for this critical program had peaked in 1987 and they have declined since. If the level of the increases which occurred in the mid-80's had been sustained, child survival funding would be around $300 million instead of a $179 million.

The bill that I recently introduced called the Aid for Development Act proposes what I consider to be a modest figure of $200 million for Child Survival Act activities. This is a bill that we hope to have earmarked in this Congress and I would ask you to react to that and to react to the declining amount of money that is going into the Child Survival Program.

Mr. BRADY. Mr. Chairman, I can give you two kinds of reactions. One is a personal reaction. It is that, indeed, the resources for this kind of activity ought to be greater for all sources. Ms. Hepburn gave us and Jim Grant and others have given us the reasons for this. There is no question what the justification is for more resources.

At the same time, there have been some shifts and some overall reductions in the resources made available to the Agency. I think, however, that we have done a very good job of trying to pull together resources from various sources—child survival funds, regular health funds, and so forth—to try to maintain a total level far beyond that of a straight child survival earmark given to us by Congress.

However, we are somewhat constrained, as you know, for various reasons. The resources available to a given country go up and down periodically making it somewhat difficult for us to plan over a longer period of time. Of course, we also have to live under the overall constraints that are given to us by OMB and, in some cases, by the Congress.

So, I guess my answer would be, yes, there is no question that more resources could be used, but we do have to make choices between where this can be and what it should be. I noticed in the New York Times yesterday that reserves of food in the world are at a lower level than they have been in about 15-20 years. Resources that we have available for the agricultural area have been reduced by some $100-$150 million. So, it is a matter of making difficult choices—where we put our resources to try to keep people alive, to try to keep them healthy and to provide them with enough food.

Mr. HALL. In looking at the numbers and looking at your statement, I want you to know that in this bill, we are not talking about increasing funding. We are talking about working within the appropriation that is given A.I.D. We are asking that out of all the categories, $200 million be spent on child survival.

Congress hopefully will support this. They have supported these efforts in the past. They are very firm about this, very committed to this, as you know. As I read one of your statements, you said, "And we must keep resources that are available focused on areas that can bring the greatest benefit," and so, I am just following up on your statement. If this is a priority, and we are getting the benefit from it which we seem to be getting, if mortality is coming down, if health is getting better, then we need to put funds into it.

We are starting to put a dent in these problems, but we have a long way to go and we cannot do it with decreased funds. If the priority is there, as you say it is, then the funding is going to have to match that priority.

Mr. BRADY. Well, I am a great believer in focus and I think Congress has helped us in that regard with the first $25 million establishing the Child Survival Fund. It did bring about a refocusing of our overall priorities and a refocusing of much of our health resources, including some of our ESF resources.

My intention—if I were boss, would be to continue with this kind of concentration in selected countries where we can do the most good and in selecting subject areas where we can do the most good because I do think that we ought to be looking for the maximum health benefit per dollar expenditure.

It is not for me to determine whether the dollar level should be at $175 or $200 million. That is between Congress and the executive branch. However, we do intend to maintain the sharp focus on these areas. We are working now to try to get oral rehydration therapy into the hands of the other 50 percent of young children and to bring about an increase in immunization against measles to the 45 percent of infants who are not now being reached.

Mr. HALL. I appreciate that answer and your focus. We are excited about this new measles technology, and what it can mean. Questions, Congressman?

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman. I just wanted to follow-up on one of your earlier questions to Mr. Grant. Unfortunately Ms. Hepburn is not with us, but I was just curious, you were—I had heard some nice statements in our great country, you know, by example, and put your money where your mouth is.

I was just curious about the—indicating how much we try very hard to teach the rest of the world to breastfeed their children, especially among them, but I am curious, what percentage of American women breastfeed their children?

Mr. **Grant**. There, I will turn to my WHO colleague on this, but after making a rather general statement which is that my understanding is that in the 1960's, the proportion of American women breastfeeding children after a several month period had dropped to less than 20 percent.

In the industrial countries a shift back as the scientific as well as the emotional and psychological merits of mother's milk has been discovered really for the first time.

In the United States today some 50 percent of American women breastfeed. Women who possess a master's degree have the highest proportion who breastfeed, even though there may be other factors. Whereas for women who have no more than a primary school education, the figure drops to well under 10 percent.

In many ways, it is they who need it most, both physically and emotionally. This really gets us back down to the challenge of education. How do we run an education campaign that appeals to those who need it most. I would argue that in the American society, we have not done enough health education.

I think I now subscribe to four health letters from Harvard and Johns Hopkins and the rest and I read the Washington Post. It has got a health section, but the people who really need it the most don't get it. In Brazil there was a conscious multiyear effort to get television to use universally popular people like the football star, Pelé. The TV global, the big private TV company with half of the audience of Brazil gave us prime time each week, the single most valuable time, they made available to us for the child survival message.

The Catholic Church has built the child survival message into the basic instruction that they now do in Brazil and in Colombia, so where they do premartial counseling, it comes in. To reach that group, it is the church, it is television, the use of these symbols, building it into primary school education, that make a difference. The world, I think, is just beginning to move on this and maybe it is very appropriate that the theme of World Health Day that is coming up is——

Mrs. **Bruggemann**. Let's talk health.

Mr. **Grant**. Let's talk health. Now, the challenge is, how do we get the people who need it the most to "let's talk health" rather than those of us in this room who have in the last 5 or 10 years become much more entrenched in health. We need to move it down the line.

Mr. **Faleomavaega**. The point I am making, Mr. Grant, despite the abundance of all that we have is available before us and has certainly been one among the industrialized countries that do this, very difficult for other countries of the world to follow if we are not the ones setting the example.

Mr. **Grant**. Absolutely.

Mr. **Faleomavaega**. I wanted to see if maybe our own country needs some education about breastfeeding. You know, I come from a very humble village in Samoa, I was breastfed and there was absolutely nothing wrong in doing so publicly, but here I get a very different feeling seeing women in public breastfeeding their children as if it were some kind of immoral consideration or rude or bad.

Yet, it is a perfectly acceptable, natural thing for humanity and I just thought that maybe we ought to do it in a way that there is a sense of consistency in sharing this basic principle. You are quite right, breastfeeding the milk from the mother is a lot healthier any time than that from a cow. I think if the Lord willed it that cow's milk should have been for humans, maybe He would have packaged it another way, but I was just curious, I thought cow's milk was for little calves and not for humans, but I don't want to prolong the issue.

I want to get on with a couple of questions.

Mr. GRANT. You may get a chuckle out of the fact that when Princess Di had her first child in the UK, she did breastfeed and we tried to take advantage of it, to get a poster, you know, discreet, of Princess Di breastfeeding the child because we thought this would be a very good example, but the protocol people in Buckingham Palace were too staid for us.

Mr. FALEOMAVAEGA. Well, we need more Princess Di's in our society to do this. One question that I wanted to ask Mrs. Bruggemann and Mr. Brady. The concern that we have right now on the Foreign Affairs Committee and I am sure this is reflected also in the budget, that the United States has had some problems in paying their bills with the United Nations, and I was just wondering, what kind of impact this has had in your programs.

Maybe I will ask Mrs. Bruggemann or other members of the panel, has it really had an impact or are we just kidding ourselves?

Mrs. BRUGGEMANN. Mr. Chairman, in response to your question, I am afraid I have to say, yes, it had an impact, but, of course, one has to look at it carefully how to express this impact because as you all know, sometimes to live under constraints makes you think twice and think hard and so, in some ways, WHO was forced to try to cope with less resources.

However, we have analyzed in our own defense—we have analyzed how exactly did it effect us. We have tried at first to keep the actual program activities untouched, so the impact was, perhaps, more felt, for example, that one stopped any recruitment of staff because there was a strong intention, at least a desire, not to make technical activities suffer.

It definitely had, if you like, a retarding effect, and, in addition, it hampered realistic thinking of what we can do next. I remember in the presentation of our own program budget, the then director-general called it a phantom budget and you can imagine what it means for your own mind when you have all the drive to go ahead, but you are not sure if you can actually go, whether you have actually petrol in the car to drive.

I must admit that it led to precise cuts in budgets even right down through our regional, to the country level, and it also led to an offer made at the time of the health assembly in 1987 to cut the already zero growth budget by another $25 million, so that, in fact, we have to some extent, a long lasting effect because one accepted that in general the budget would go down—$25 million may not sound much, but if you have a total of only $400 million per year, than that is already a percentage that is noticed.

So, I am afraid I have to say, yes, it has had an impact and the reassurance now, that WHO can count on the U.S. contribution does make a difference.

Mr. **Faleomavaega**. Thank you. I would like to ask the gentlemen from Minnesota.

Mr. **Penny**. Thank you, Mr. Chairman. I wanted to ask Mr. Grant if he is aware of any arrangement or agreement that will provide for a continued collaboration between the United States and the U.S.S.R. in terms of funding the these international efforts. Evidently and I think in your testimony, you may mention that the Russian contributions were increased dramatically in the recent past and I am just curious to know if there is any long-term commitment in that regard or if further negotiations and discussions have to proceed in order to pin that down.

Mr. **Grant**. Well, following the summit statement by Mr. Gorbachev and Mr. Reagan, as I indicated, WHO and we received a rather basic letter from the U.S.S.R. I must say it was done rather skillfully. They waited till the day after Dr. Mahler left and the new director general came in so they were addressing the new director general, maybe unfair to Dr. Mahler, but skillfully——

Mrs. **Bruggemann**. Politically.

Mr. **Grant**. Politically, well done, and promised increased interchange in technical support with WHO to which they make access contributions, to UNICEF he said, "We will significantly increase our financial contribution which since has been voluntary, has been at the $1½ million level, really quite insignificant.

That was followed up this spring by a further communication under which they increased their contribution twelve fold and said this was the beginning of a pattern of increases of working with UNICEF. They have invited me to——

Mr. **Penny**. The twelve-fold increase was UNICEF alone?

Mr. **Grant**. UNICEF alone. If you take the current exchange rate with its limitations for evaluation. It went up in effect from $1½ million to just under $20 million. They have invited me to come to the U.S.S.R. for discussion about how they can participate more meaningfully in this child survival effort that is going on.

I would say on this that when Mr. Foege speaks, you could pursue some of this question with him because the smallpox eradication program, that was really an example of the U.S.S.R., U.S. initiative with the two playing a common role on the concept of polio eradication.

As you know, while both Salk and Sabin are Americans, Sabin did his basic work in the U.S.S.R. Polio work developed there and we then took it back from there for ourselves. There has been a great deal of interest in the U.S.S.R. in working together on the health field globally. Ever since last fall when Mr. Shevardnadze in October made a statement that sought major areas where we can work together on global problems. This idea of the health of children has begun to take root in this and our hope is that this will move forward. I have absolutely no doubt if there is a world summit on children, for example, that the U.S.S.R. would respond positively.

Certainly, if the United States were to take the initiative on this idea for a summit, they would happily come in and, I think, play a significant role in this.

Mr. **Penny**. I would also like to ask a question about the issue of Third World debt restructuring. It seems to me that some debt forgiveness has to occur and short of that, there isn't much relief in reality that is going to be experienced by these countries. If there isn't relief of this pressure, they are not going to have the wherewithal to do much restructuring within their economy or reallocation of resources within their economy.

Do you have a notion and this may differ from country to country, do you have a notion of how much write-off we are actually going to have to shoulder in order to make a difference in terms of the development efforts in these countries?

Mr. **Grant**. If I may say, I would agree completely with you that there has to be a significant debt write-off if you take the global total. Second, as you indicate, it should be tailored country to country because some have a lot more resources than others.

My own and I clearly have to speak personally here, but I have put a lot of time in on this, I myself think that the sort of global figure of 20 percent debt relieve that has been used is too low. I would say that a significantly higher figure between 30 and 40 percent obviously applied selectively would be required to restore dynamism back to these economies and I would say that this dynamism is needed not only obviously for children on the social sides. Back in the 1960's and 1970's when I was at the Overseas Development Council, by far the fastest growth in U.S. exports was to the Third World, particularly to Latin America. I don't think there is much doubt that if we could restore dynamism to Latin America in particular, that this would make a $30, $40, $50, $60 billion difference on our balance of payments and I belong to that group of economists who believe that if you are going to restructure the U.S. deficit and the German-Japanese surplus problem and do it on the framework of both rather than recession, we need a growing world economy and its dynamic growth in the Third World.

So, it seems to me that we would benefit from erring on the side of a little more debt relief because that would restore the dynamism that we need to get through this rather difficult period in the next 4 or 5 years of moving from being a massive international debtor country back to some kind of balance.

Mr. **Penny**. Thank you.

Mr. **Faleomavaega**. I just have one more question for Mr. Grant. Mr. Brady, did you want to comment to the——

Mr. **Brady**. I would like to comment on the question you asked the two of us with regard to U.S. funding of WHO, and here again I speak as a scientist. As you know, funding is the responsibility of the State Department, not U.S. A.I.D.

However, I think we can say that several organizations in the United Nations had management problems that we felt needed to be looked at. I think WHO was one of the first to begin to make some very critical changes. As a consequence, even when we were cutting down, I think, WHO's support was cut less than some of the others.

In this last year, State will be funding our full assessment and, I understand, that plans being presented to Congress will make up back payments so that we can get fully back on board. It is recognized that, of course, because of the change in the value of the dollar, it has been much harder for us to maintain our levels of input into some of the United Nations programs. In some cases, I think countries have actually been able to pay in their own currencies and thus reduce somewhat their input because the dollar value of those currencies went up. I would also point out, of course, that there are about 49 other governments that, for various reasons, have not been able to make their payments to WHO. We are concerned about it. We should be able to come back and be paying the full amount because I personally feel that WHO is a well run organization.

Mr. Faleomavaega. Thank you, Mr. Brady. Pursue the question, Mr. Grant. You had alluded earlier about the devastations of war and that stands without any question as during my own experiences as a Vietnam veteran. The children suffer because of bad economic conditions caused by war and I was wondering what percentage of children suffer because of war in contemporary times.

Mr. Grant. Well, I mean, if one takes Sudan where I have been most immediately involved, last year about 250,000 died. Over one-half of these were children, kids 12 or under. They are the weakest and the most vulnerable.

The second statistic, of course, that hits you very hard is that the death toll in that civil war is overwhelmingly civilians. There were not 25,000 soldiers killed in that fighting, probably less than half that. The civilians caught in the middle bore the great brunt.

This is true in most of the wars that are going on today. Certainly in Angola and Mozambique, this has been the case. Some 150,000 children died last year in Angola, Mozambique, as a consequence of the conflict there, this number far exceeds the soldiers on either side by many times.

Mr. Faleomavaega. And this is the irony of this whole circle or cycle that we are talking about, Mr. Grant, because my next question may not be very comfortable. What countries of the world sell and provide planes, guns and bullets for these other countries to continue the war and fight the way they do.

The contradiction that it is apparent to me is that it is the industrialized countries which provide the implements of war, cause so much suffering among the children of the world.

This is somewhat of an irony and a contradiction. On the one hand, we very much want to help the children of the world, and on the other hand, we are the ones selling the bullets and the planes and the guns and everything else to destroy the children of the world. I am talking about all the countries that can produce planes and things of this nature, not necessarily just our own country.

I am talking about all the industrialized countries. Don't you find this as somewhat of a contradiction?

Mr. Grant. Yes, and I would say that what we do need is a new ethic to emerge——

Mr. Faleomavaega. In the summit conference that you had suggested.

Mr. **Grant**. An ethic that makes it really unconscionable for countries to engage in the arms trade. Now that the Cold War seems to be coming to a very different phase and moving out of the military site it certainly should be an appropriate time to make it unconscionable to engage in this trade.

Unfortunately, what we are seeing is that if we are not careful the decline of the Cold War will step up the pressure on governments to support their arms manufacturers, to sell these arms on the world market because they themselves may be reducing arms and in order to keep the arm industry going, they will take an active role to promote the sale of arms. This is what we have been seeing, plus the fact that we have seen the entry of Third World countries increasingly to the arms industry.

So that a country such as Brazil has become a major supplier. India is on the way to becoming a major supplier. This is an arena in which one does need a new convention, a new set of attitudes on that we haven't really focused on yet.

Mr. **Faleomavaega**. Mrs. Bruggemann, Mr. Brady, Mr. Grant, thank you very much. We really appreciate your participation.

We have with us here a second panel consisting of Mr. William Foege, executive director of the Task Force for Child Survival with the Carter Center in Atlanta and also Mr. Herbert Pigman, director of Rotary International Immunization Task Force.

Please come forward. We will hear your presentation and I would like to ask Dr. Foege if he would like to begin. The chairman will be back, he was interrupted, and I am pinch-hitting for him until he returns.

STATEMENT OF WILLIAM FOEGE, M.D., EXECUTIVE DIRECTOR, TASK FORCE FOR CHILD SURVIVAL, THE CARTER PRESIDENTIAL CENTER

Dr. **Foege**. Thank you very much. I do have a prepared statement which I will provide for the record and just make some comments if that is OK with you.

It is gratifying to see this much attention being given to international health and specifically child survival. In the past decades, there have been some spectacular gains and one sees in a short 10 years, that efforts have gone from a desire for better immunization coverage, for instance, to an actual global program started by WHO in the 1970's and then greatly strengthened by UNICEF in the 1980's.

This leadership of the U.N. agencies has now been matched by a great increase in resources, not just the U.S. Government but Canada, the European countries, Rotary International but especially by the developing countries themselves.

I think we often overlook this fact that the developing countries have greatly increased the amount of money they are putting into child survival. We have also seen the courage to set a goal of universal access to immunization by the end of next year and we also see, as Mr. Grant has pointed out, an increase in political will country by country and a change in the social norms so that increasingly, it is no longer acceptable not to immunize the children.

We have also seen a coordinated effort at research and development, applied research and development that has been funded by the United Nations Development Program, Rockefeller Foundation and UNICEF and the sum total of all of this is an increase in coverage which is really quite spectacular. It was estimated 4 years ago, that about 20 percent of children in the developing countries had received a third dose of polio.

Now, WHO tells us that figure is over 60 percent and some 80 percent of children have actually received a first dose of some vaccine which means they have access to a system, so we are coming very close to that goal of universal access by the end of next year.

There also have been some other encouraging trends that we have heard about, such as a decrease in infant mortality rates. Mr. Grant pointed out that we now have several million children a year that are saved because of immunization programs and diarrheal disease programs, but I would add that there are now some 7 million couples every year that don't lose a child before the first birthday that would have if we still had the same infant mortality rates of 1960.

We are also beginning to see a decrease in birthrates. These successes have led to some even more ambitious goals and I would point out specifically the goal of polio eradication from the world. The goal in this hemisphere is to have no more polio by the end of next year and for the world as a whole to have no polio by the year 2000.

There have also been some new goals of trying to reduce measles deaths by 90 percent by the year 2000, and to decrease the deaths from acute respiratory infections by 25 percent. A question was asked before, What concrete evidence do we have that the Soviet Union is going to participate in all of this?

The Soviet Union is providing this month a scientist from Leningrad who will be working for the next year with the Task Force for Child Survival to map out the collaborative efforts that the United States and the U.S.S.R. could take in this field.

I think that the final point I would make is that we now have an infrastructure around the world for delivering immunization so that the world will be able to take advantage of the new vaccines that are now on the horizons.

Finally, I would like to say we do face a major problem with population growth in that the toll that that imposes on both resources and the environment is going to be very great. We have to continue a direct assault on population growth but at the same time, we have to point out something that appears contradictory. A decrease in infant and childhood mortality actually leads to a decrease in birth rates.

The fears that saving children from death somehow makes our situation worse is unfounded. The world gains by having a decrease in infant mortality because that leads to a decrease in birthrates.

I would also say that the United States gains. We live in an interrelated world and that is especially true of health. We saw in some of the previous testimony that while the United States did not have smallpox at the time we began contributing to the smallpox eradication program, it was costing us money to keep smallpox out of this country and the U.S. contribution over a 10-year period is recouped every 3 months so that we save more money than any other country now because of our investment in smallpox eradication.

The same is true for other diseases. The money we contribute to the reduction of polio and measles, reduces our threat of importation and at the present time, we have about two importations of measles every week into this country.

We also benefit indirectly by a more stable world, a healthier population and a healthier economy. The United States can provide some significant leadership by giving both full scientific and financial support.

Our refusal to honor our obligations to WHO which came up in the last panel, I think, is a significant one. We still have $27 million arrears that we owe the World Health Organization. This not only has reduced the resources that WHO has available, it has caused great confusion in that organization of not knowing what to expect from the United States and I must say, it is also reduced the credibility of those of us in this field who happen to be Americans. So, I would urge generous, helpful, and bold support of global health and child survival for both bilateral programs and through out United Nations agencies. Thank you very much.

[The prepared statement of Dr. Foege appears at the conclusion of the hearing, see p. 107.]

Mr. **Faleomavaega**. Thank you, Mr. Foege. Mr. Pigman.

STATEMENT OF HERBERT PIGMAN, DIRECTOR, ROTARY INTERNATIONAL IMMUNIZATION TASK FORCE

Mr. **Pigman**. Thank you, Mr. Chairman. What you will hear in my oral testimony is a case study on one private voluntary organization. In 1985, Rotary made a commitment which was considered extraordinary for PVO and that was to provide polio vaccine for 5 years for the more than 100 million babies who were born each year in developing nations.

We also said that we would marshal the support of our Rotarians who are business and professional leaders in these communities to help the health sectors solve some of the problems of vaccine delivery and communications and logistics.

This offer was frankly greeted with some skepticism by world health leaders because here is an organization stepping forward with this kind of pledge with no money in the bank, no track record in health management program, et cetera.

Our goal was a $120 million to buy the polio vaccine and that goal was not only met but far surpassed. In 2 years, 30,000 Rotary trained volunteers raised $230 million and it cost 5 cents on the dollar.

We learned we were in the education business and what we learned is that there is a very deep well of compassion among all peoples about the plight of children and among men and women in this country and other industrialized nations, there was dismay and disbelief when they learned that so many children even today are dying of these vaccine preventable diseases.

We found that the dream of a polio free world was very effective in educating people and we were very pleased last May when WHO adopted all 166 member nation voted unanimously to adopt the year 2000 as the target year for eradication of this disease.

Now, the U.S. Agency for International Development made a challenge grant to a Rotary of $6 million. It was the largest single grant to a private voluntary organization that year and to show you how an example of the loaves and fishes, Rotarians responded by contributing $120 million of their own.

Like the eight agencies of nine other governments who supported our PolioPlus Campaign, U.S. A.I.D. applauded the way the Rotarians can multiply a small amount of money into rather significant amount, donations in cash and kind from private sectors in their nations.

We spend about 95 percent of our funds on vaccines and 5 percent on mobilizing voluntary manpower and this second 5 percent is the most valuable component of the program. Ms. Hepburn spoke of Helping Hands. By this time next year, India will have a voluntary immunization task force of 50,000 Rotarians, spouses, and young adults who are going to help health workers get vaccines to babies in slums and in other undeserved areas of urban India and many of these volunteers are pledging 1,000 or more hours of personal time during the next 4 years.

Now, because we have an established network of people who meet weekly, we have been able to recruit and train these volunteers in India for about $4 per person per year. The chairman ask for our comment about eradication plans. We believe that the polio eradication goal is a tremendous goal for mankind.

I believe that it is going to be the horse that pulls the EPI cart. When WHO created a plan for the global eradication of this disease, Rotary was the first among all organizations in governments to step forward with funding. They seek $155 million in extraordinary funding and the start-up funds that Rotary provided are enabling WHO to develop immediately a team of technical experts who are going to help nations design their polio eradication programs.

I think that the strategies of the global polio eradication plan are sound, simply stated, they are to raise and sustain immunization coverage to assure quality vaccine, to keep it cold, to identify all polio cases, to develop laboratory diagnostic capacities and to strengthen communications.

In summary, Mr. Chairman, we believe that health leaders at all levels, national, preventional state, and community need to involve more private voluntary organizations and leadership groups.

They need to work together to identify specific ways that the private sector can help in the nontechnical aspects of polio eradication strategies. We hope that what Rotary and many other fine nongovernmental organizations are doing will contribute to public demand and support for commitment of even more resources to the immunization of children.

In the battle of the coming decade, all hands are going to be needed. Thank you.

[The prepared statement of Mr. Pigman appears at the conclusion of the hearing, see p. 122.]

Mr. **Faleomavaega**. Thank you, Mr. Pigman. I listened with intent and quite impressed of the fact on the 95-5 percent ratio in terms of how the money is to be spent, I wish every agency in the Federal Government can do likewise and perhaps to provide more effectiveness in the way we utilize our funds.

I have always admired and with great respect what Rotary International had done for the communities throughout the world and certainly you are to be commended. In this area, as you have indicated, Mr. Pigman, Rotary International, how many other private, nonprofit organizations are involved in this same area?

Isn't there also the participation from Lions International, particularly this area of polio eradication or is this just your own effort?

Mr. **Pigman**. I think the service club movement grew from the United States voluntary concepts and today there are probably 4 million members of some 30 service clubs who are headquartered in the United States and around the world.

Some of these have programs that support primary health care, but I don't know of any that have quite the program that Rotary has with respect to polio or any of the other communicable diseases that are vaccine preventable.

We hope that Rotaries input into this field will encourage other PVO's to do likewise and we would be very happy to share our experience of course.

Mr. **Faleomavaega**. I get the impression that WHO was not exactly willing or positive in terms of your proposal initially, what seems to have been the problem. Do they prefer to do the implementation themselves? Can they do it better than what you have done?

Mr. **Pigman**. I think that WHO treated Rotaries offer with conservative attitude for good reason. They had experience before with voluntary groups who would come in to let us, say, an immunization situation and drop in like a parachute cord, vaccinate a few children, grab a few headlines and disappear.

The whole thing here is sustainment, sustainment and for that reason, we have emphasized in Rotary that to do something like this is to sweep the ocean back with a broom and we are in for the duration of the battle and try to educate our members to the fact that immunization is ongoing and that all our efforts must be designed so that the health infrastructure of the nation is strengthened and eventually, they are the ones who must carry on the battle for immunization of children.

We cannot expect that private voluntary organizations are going to be able to fund this type of thing year after year after year. They are in for the relatively short term and I think that we should all make the most of their input at the moment.

Mr. **Faleomavaega**. Mr. Foege, I just want to ask one question on the presidential center named in the honor of former President Carter. I am just curious, what are some of the major projects that you are undertaking right now besides Marietta or——

Dr. **Foege**. Mr. Chairman, we have projects in 20 countries around the world that have to do primarily with agriculture and with health. And in agriculture, we are attempting in Africa to see if the Green Revolution of India and Pakistan can be repeated in Africa.

We have hired Dr. Norman Borlaug who received the Nobel Prize in 1970 for the Green Revolution in India and Pakistan and he has become encouraged that we will see in Africa the same sort of change.

Indeed, he is predicting that within a couple of years, we will see the first national Green Revolution in Africa, in Ghana. We are also working on Guinea worm eradication. Guinea worm is a disease also related to agriculture because when people have Guinea worms, they are unable to do the planting and the harvesting.

Guinea worm involves about 10 million people a year, most of them in Africa and we are attempting to eliminate this disease by 1995. We are having great success in the first three countries: Pakistan, Ghana, and Nigeria and this program is now going throughout Africa.

We also have a series of other programs on rehabilitation, special education with China and so forth, but basically health programs. If I can give one follow-up to your previous questions of WHO and their reluctance to embrace polio eradication. I think the strength of WHO obviously is that it is made up of a 160 countries and, therefore, when a decision is made, it is a global decision, not a partial decision.

That is also the great weakness of WHO, in that you have to get 160 countries to agree to something before you can establish it as a global objective. I think the nice thing about the polio eradication program is the fact that we do have a global collaborative effort at this point. With UNICEF and WHO not only working together, but putting out joint documents. It is to the credit of Rotary that they joined that coalition and did not try to do their own program.

They worked very closely with the global umbrella assisting UNICEF and I think that this is one of the real lessons we are learning, that you can go much further, much faster with a collaborative effort rather than everyone doing their own thing.

Mr. FALEOMAVAEGA. You indicated earlier, Mr. Foege, that you're disappointed that our country has not given, was it $27 million short that we should have given WHO?

Dr. FOEGE. That is right.

Mr. FALEOMAVAEGA. I get the impression that WHO has had the same problems with UNESCO, questions of accountability, questions of poor management and perhaps even corruption. I don't see your concern for an organization that perhaps is not carrying out its function. I think this is probably one of the main reasons why we, of course, considering the debt problems that we are having in our own country, but more especially, the whole thing evolved out of the fact that some of these agencies were so inefficient and for that matter much of the money is simply wasted.

Dr. FOEGE. And I am all for controls that look for efficiency in spending. I think, however, our own State Department in evaluating the U.N. agencies came out with a report saying that WHO was the most efficient of the U.N. agencies and then by very perverse logic, they said, therefore, they could take the biggest cut because they are so efficient in their management.

That doesn't make sense.

Mr. FALEOMAVAEGA. Thank you very much, gentlemen. There will be more questions submitted to you, I suppose after this, but I really appreciate your coming here. Thank you very much. The meeting is adjourned.

[Whereupon, at 12:45 p.m., the Select Committee on Hunger was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF NYLE BRADY, SENIOR ASSISTANT ADMINISTRATOR, BUREAU FOR SCIENCE AND TECHNOLOGY, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Good morning. It is a pleasure to appear before this committee to testify on the role of the Agency for International Development (A.I.D.) in meeting the basic health needs of children and mothers.

Health is an essential element of the Agency's development program. There is perhaps no greater indicator of underdevelopment than the inability of countries and families to ensure the survival of their children. Globally, tens of millions of children are born each year into an uncertain world where their very survival is in question. In addition, worldwide, more than half a million women die each year from causes associated with pregnancy and childbirth.

All too often, poverty is the common denominator of disease and premature death. The long-term answer to improved health lies in sustained broad-based economic growth. Broad-based economic growth is essential to increase household incomes for families to obtain their food and health care and to increase resources for governments to undertake priority improvements in health infrastructure.

At the same time, we now know that much can be done to promote better health among the most vulnerable of the low income populations. Effective low-cost technologies addressing the most common causes of mortality can have a direct effect. More importantly in the long run, broad-based health care delivery systems can be built upon these technologies and lead to sustained improvements in health and life expectancy.

The overall goal of A.I.D.'s health assistance program is to improve health status in assisted countries as reflected in increased life expectancy. Most health problems in developing countries stem from infectious and parasitic diseases; poor environmental conditions; lack of health care and knowledge; and malnutrition. Hundreds of millions of adults suffer from chronic illness, but children are most likely to die from severe episodes of childhood diseases that are rare or have little impact in the developed world. Half of all deaths in developing countries occur in the five-and-under age group.

For this reason, A.I.D. believes that the most direct way to increase life expectancy and general health status in developing countries is to address the health problems of children and their mothers. Therefore, the primary objectives of the Agency's health sector activities are to:

- -- reduce infant and early childhood mortality by increasing immunization coverage, reducing diarrheal disease mortality, improving nutrition in young children, and improving birth spacing and maternal health;
- -- reduce maternal mortality and morbidity;
- -- use child survival interventions as the basis for building a more comprehensive health care system which, over time, can ensure that gains made in improving child survival and health are sustained; and
- -- develop new technologies and improved delivery systems.

A.I.D.'s strategy is straight forward: to focus its resources on delivering the most effective known technologies and concentrating its efforts on countries where the need is greatest and where U.S. assistance can make a difference. A.I.D. supports its field programs with technical expertise and results oriented research. A.I.D. is committed to involve the private sector, to collaborate in this endeavor with other donors and groups, and to monitor and evaluate results carefully.

Roughly 60 percent of the funds that the Agency commits to health are for Child Survival activities. As you are aware, A.I.D. has long been concerned with the state of children's health in developing world. With supplemental funding and a strong mandate from Congress, A.I.D. launched a child survival program in 1985. Since that date, the Agency has committed over 600 million dollars from various funding accounts to Child Survival programs in more than 60 countries. Between 1985 and 1990, the Agency will have committed one billion dollars to Child Survival programs.

Remarkable strides have been accomplished in the name of child survival . . . accomplishments counted in children who now receive life saving treatment of ORT to prevent dehydration associated with diarrheal diseases, in children who now benefit from the protective effect of vaccinations, in families who see that they can protect the health and lives of their children, and in improved technologies that can broaden the impact and lower the costs of child survival programs.

* * *

The accomplishments are remarkable. To be sure, the number of children dying remains unacceptably high. Nevertheless, in many countries, the prospects for survival for a child born today are clearly better than for those born just five years ago.

The accomplishments of child survival are all the more remarkable in that it has become a truly global movement, the result of an international partnership that joins developed and developing countries, international and private organizations, educational institutions, individuals and communities.

It is to the credit of everyone involved - - including the organizations represented at this hearing and especially the countries of the developing world - - that so much has been accomplished:

-- Globally, in 1980, less than 20 percent of infants under age one were vaccinated against measles; today 55 percent have been reached. Even higher levels of vaccination have been achieved for the other vaccines.

-- In 1980, ORT was used in fewer than one percent of diarrheal episodes. Today, ORT is available to more than half of the world's children and is used in more than 25 percent of diarrheal episodes.

-- Worldwide production of ORS packets increased by 300 percent from 1983 to 1986. Enough ORS is now produced to make 330 million liters of solution a year. And two thirds of that ORS is now produced in developing countries.

While it is too early to expect to measure impact with full accuracy, evidence that morbidity and even mortality patterns are changing is growing:

-- Infant mortality associated with diarrheal diseases declined by half in Egypt between 1983 and 1986. The Government of Egypt estimates that the national infant mortality rate has fallen to below fifty deaths per thousand live births. In Ecuador, there has been more than a fourfold decrease in the number of deaths of children under age five attributable to vaccine preventable diseases.

- -- Studies in India, Indonesia, Thailand, and the Philippines have documented declining infant mortality and illness in hospital based programs promoting early and sustained breastfeeding.
- -- Even in Africa where mortality is highest and delivery of services most difficult, we are seeing the effects of the efforts of programs such as the twelve-country African Child Survival Initiative in increasing rates of immunization and declining mortality rates from diarrhea in hospitals.

The 1980s has truly been a decade of achievement in child survival. However, as we look to the 1990's, the first challenge will be to sustain the hard won gains of the 1980s.

Child survival programs face an annual test of sustainability - - the ability to continue to deliver services without major external assistance. Each new cohort of children tests the system again. Shortfalls in budget allocations for vaccines and breaks in the cold chain due to inadequate maintenance can only too quickly be reflected in diminished immunization coverage and disease outbreaks. Failure to reinforce new ways families have learned to treat diarrheal disease could show up rapidly in a decline in the use of ORT and a return to former levels of diarrheal related mortality.

Many would broaden the mandate of child survival, redefine its goals, or diversify the efforts. This would be a mistake. We need to ensure that what has been accomplished can be sustained. And, we need to recognize that many of the children at greatest risk have not yet been reached with critical services. We need to complete this important task.

Sustainability is an issue that is not limited to the health sector. The Development Assistance Committee of the Organization for Economic Cooperation and Development reviewed the experience of its 18 member countries in sustaining development programs in a number of sectors.

This review identified seven critical factors for sustaining development projects in any sector: government commitment and policy; management and organization; financial factors; technological factors; socio-cultural factors; environment; and external factors.

Sustainability was the theme of the Third International Conference on Oral Rehydration Therapy (ICORT) held in December 1988 and sponsored by A.I.D. together with the World Bank, WHO, UNICEF and the United Nations Development Program.

Ten years ago, ORT was virtually unused and little known as a public health tool. In 1983, the first ICORT was held to make the treatment better known. ICORT II was held in 1985 for health professionals to share their experiences in developing and carrying out ORT programs. With ORT available to more than half the children of the world, the purpose of the third ICORT was to draw attention to the need to sustain these programs. More than 500 participants from 50 countries were asked to share their experiences and challenged to present their ideas for sustaining ORT programs.

Ministers of health and finance, program planners and managers described solid progress and dramatic success in Egypt, Indonesia, Malawi, Haiti and elsewhere. Representatives from country after country reported on expanded programs that have resulted in increased knowledge and use of ORT. They shared problems and solutions and contributed to the growing evidence on some of the benefits of ORT:

-- fewer hospitalizations for dehydration;
-- lower costs for government programs;
-- lower family expenditures for diarrhea treatments; and
-- most important, fewer diarrheal deaths.

But the purpose of the meeting was to look forward, to stimulate candid discussions and creative solutions to the problems of sustaining ORT programs in the next decade. Among the participants there was little doubt about the magnitude of the problem. Health budgets in the developing world can barely be expected to keep up with the needs of the growing populations. Donor assistance cannot be expected to fill the gap. Many of the most vulnerable have not yet been reached and technical issues still constrain program impact. Yet, there was an air of optimism at ICORT III and, despite the diversity of country situations represented, a number of common themes emerged:

- ORT programs ultimately depend on families. Mothers and other caregivers must recognize the problem and act promptly and effectively. They need the knowledge and the means to identify and treat diarrheal disease. Given these, most families will act, if they can afford to - in terms of time as well as money - and if they are convinced that they are doing what is best for their children. For new behaviors to be sustained over time, they need to be reinforced by other family and community members; for unfamiliar skills to become second nature, they need to be repeated until they are learned.
- Sustainable programs must be affordable by governments and by families. As Dr. Nakajima, the Director General of the World Health Organization urged, programs must be based on activities that "countries themselves can afford in the long run without external donor resources." Governments must find the means to sustain services which only they can provide and encourage the private sector to provide other services. Similarly, families and communities need to be self-reliant. Many are willing and able to pay for ORS.
- We recognize that if programs are to be sustainable, the private sector must be enlisted. The public sector has an essential role to play but it cannot sustain ORT programs alone. When both government and private sectors advocate and practice ORT, the treatment of the patient is improved,

professionals reinforce each other's and families' knowledge and the costs of treatment are lowered. Similarly, others in the private sector, for example, producers, distributors, private voluntary organizations, pharmacists, teachers, religious and other community leaders, traditional healer and others need to be drawn in. As with ORT programs, Rotary International's PolioPlus program is an outstanding example of how the private sector can contribute on a large scale to child survival programs and how public finance can be multiplied many times over by private contributions and effort.

- The control of diarrheal diseases can revitalize and strengthen the entire health system. It can help build logistics systems, develop training and communications capabilities, strengthen case management and information systems and change the attitudes of professionals and patients.
- More attention to training is essential to build the human capital for sustained efforts in diarrheal diseases. Training must reach the public and private sectors, and schools of medicine, nursing and pharmacies need to change the curriculum that is forming the next generation of health workers.

- Evaluation and research make essential contributions to sustainable ORT programs. Although we spend only a small proportion of our funds on evaluation and research, these investments are key in making sure that we learn from experience and that inadequate technology does not constrain success.

Finally, ICORT itself was evidence of progress on what many cited as the most critical factor, that is the importance of national commitment. If programs are to be sustained over the long term, they must be the priority of the country and the community. As Secretary of Health Alfredo Bengzon of the Philippines described the development of his country's national plan for diarrheal disease control, "It may not be a perfect plan, but it is clear, courageous and above all, it is ours: we made it, we approved it, we are committed to it... In a sense it is more than a plan. It is a statement of our will".

This kind of commitment will be necessary as we face the other challenges of the 1990's. Sustainability will be the issue for the next decade and child survival programs will need to pay serious attention to financing and other issues to ensure their long term viability. As we see it, the job is but half done. Therefore, child survival will remain the focus of our health efforts well into the next decade.

At the same time, there will be other pressing needs and opportunities in the health sector. With the resources that we have available, our priorities are to:

-- help stem the spread of AIDS;
-- improve health care financing;
-- contribute to greater availability of water supply and sanitation;
-- develop improved technologies for priority health needs, such as vaccines for malaria and other diseases of childhood;
-- improve maternal health care; and
-- increase attention to tropical diseases, especially the resurgence of malaria and other vector borne diseases.

The challenges ahead are real and sobering. Donors and developing countries alike will face economic constraints and will need to make hard choices among programs competing for scarce resources. Population growth will continue to pose a challenge for health programs, notwithstanding dramatic successes in family planning programs around the world and decreases in total family size. Disease patterns, including epidemics characteristic of unhealthy, polluted and crowded urban settings and new diseases carried by vectors adapted to urban environments, will place new demands on already overcrowded health facilities and workers. And, although the changing population distribution and the resulting aging of populations can be counted among the success stories of development, the health needs of the aging will confront health systems ill-prepared to deal with chronic diseases.

These are new issues, in one sense, and yet the same old issue - - resources. The problems of the next decade will require resources. The economies of developing countries must grow more rapidly to provide resources for health and other important programs. The incomes of families must increase so that they can meet their needs. And, we must keep resources that are available must be focused on areas that can bring the greatest benefit.

We believe that we have charted an effective course toward the goal of improved health in the developing world. The prospects for survival of every child born in the developing world are clearly better than they were even a few years ago. A.I.D. has played an important role in these efforts. We are committed to continuing this effort with the leadership and support of the U.S. Congress and the American people.

ADDITIONAL QUESTIONS FOR NYLE BRADY
SUBMITTED BY HON. TONY P. HALL

SECTOR ADJUSTMENT IN HEALTH

Mr. Hall:	A.I.D.'s Africa Bureau is presently involved in sector adjustment activities in health as part of its African Economic Policy Reform Program (AEPRP). Please provide us with details on health and education sector adjustment activities under AEPRP, and whether we should see this as a trend for the future.
Answer:	We are currently designing an education sector AEPRP in Mali, a health sector AEPRP in Kenya and another health sector AEPRP in Nigeria. The Mali effort is part of a multi-donor program including the World Bank and the French. The Mali education system is extremely ineffective and limited in access (under 40%). Given the number of children who drop out or repeat grades, it takes an average of twenty-three years of schooling for a child to complete primary school. Among other ills it suffers from: -- lack of teaching materials -- misallocation of teachers -- poorly trained teachers -- too few resources going to primary education The program we are developing will deal with all of these issues -- reallocating budget, retiring some teachers and retraining others, ensuring relevant teaching materials are in place, etc.

The health sector AEPRP in Kenya deals with a similar problem -- a health sector which is largely devoted to providing curative services to an elite, and which does that very poorly. The A.I.D. program will seek to improve the quality of curative services, increase the degree to which these services are paid for by users (through the introduction of a broad health insurance scheme), and shift resources to preventive, primary health care. The Nigeria program, which is not yet fully developed, with take a similar tack.

We see these sector programs as examples of future activities that could be developed in this sector for other countries. Non-project mechanisms are the best vehicle for addressing sectoral policy problems, such as rationalizing the use of resources going into a sector, if we can persuade the host country and other donors active in the sector to agree on a common approach to solving major sectoral policy problems. If successful, such non-project mechanisms should provide sustainable solutions. This is the kind of AEPRP we envision in these sectors, but which specific sectors we will be involved in will vary each year.

DEFICIENCIES IN MICRONUTRIENTS

Mr. Hall: The select committee and many others have become aware in recent years of the importance of vitamin A. We are now hearing that deficiencies in the intake of other micronutrients, such as vitamin C, iron, and iodine, are harming children, refugees, and others in need. Are micronutrient deficiencies evident among groups served by AID's Child Survival, Health or Nutrition programs? Can the supply of properly fortified foods effectively mitigate these deficiencies? What is A.I.D. presently doing to respond to this problem?

ANSWER: Micronutrient deficiencies are evident among groups served by A.I.D.'s Child Survival, Health and Nutrition programs. From nutrition survey data, we have information about multiple micronutrient deficiencies in malnourished populations. Problems of acute deficiency in iron and folate, and vitamins B 12, C, and A have been identified in refugee groups in Asia and Africa. More importantly, these deficiencies affect and have been noted to be widespread among the poor in developing countries. As in most deficiency diseases, women and children are the most seriously affected.

In order to address, in the short run, micronutrient deficiencies among recipients of donated commodities, vitamins and minerals are being added to these commodities and to blended foods. A.I.D. supplies large quantities of cereals processed and fortified food products, and oils to dislocated populations who lack access to adequate food. In situations where micronutrient deficiencies exist, preference should be given to the use of fortified Title II products. In addition, where appropriate, Vitamin A and C and iron deficiencies are being treated with capsules and tablets. Vitamin A levels are being increased by over 40% in blended foods and by over 100% in all other processed foods. Under the Title II program, blended foods are enriched with a vitamin/mineral premix and distributed in many countries including Mauritania, Sudan, Ethiopia, India, the Philippines, Sri Lanka, Bolivia, and Peru. In view of the seriousness of micronutrient deficiencies, A.I.D. periodically reviews the levels of micronutrient fortification used in title II foods. However, in the long run, sustainable improvements in nutritional status require regular consumption of indigenous foods supplying all the necessary nutrients.

A.I.D. has been a leader in identifying and addressing micronutrient deficiencies and, with the World Food Program, the United Nations High Commission on

Refugees, other bilaterals and donor groups, is implementing intervention programs to reduce these deficiencies. For example, A.I.D. supports the World Health Organization (WHO) programs for treatment of iodine deficiency disorders. A.I.D. is a major supplier of fortified foods to the World Food Program.

The Office of Nutrition supports research on the role of vitamin A deficiency in blindness, childhood disease and death. Short term (high dose capsule distribution) and long term (fortification, nutrition education, gardening) interventions are underway in over twenty countries. A.I.D.'s program in combatting iron deficiency anemia includes research into new fortification technologies, development of slow release iron capsules and improved methods of assessment.

ROLE OF A.I.D.'S OFFICE OF NUTRITION

Mr. Hall: Please provide information on the role of A.I.D.'s Office of Nutrition in meeting the basic health needs of children and mothers in developing countries. Is the Office working with other parts of A.I.D., such as the Office of Health or the Bureau for Food for Peace by advising them on the nutritional component of their activities? If so, how? If not, why not?

ANSWER: A.I.D.'s Office of Nutrition provides (1) direct programming and technical advice to the Agency on the nature, extent, and causes of malnutrition in LDCs; (2) technical support for program operations to overcome deficiencies, and; (3) evaluation services. Children and mothers benefit from several projects. Examples include:

1. The project on the "Improvement of Maternal and Infant Diet," focuses on breastfeeding and appropriate weaning practices, the dietary management of infant diarrhea, and household nutrition and health. It also is a clearing house for relevant information for policy makers and professionals in LDCs. This permits the Office to help the Agency set priorities, evaluate the program for gaps, duplications, or inefficiencies, respond to changes in funding levels, or evaluate new proposals. This supports A.I.D.'s child survival strategy. The Office of Nutrition works closely with the Office of Health in this area.

2. The project on "Vitamin A for Health" helps developing countries with the prevention of vitamin A deficiency and resulting nutritional blindness. The Office of Nutrition has provided co-funding to an Office of Health research study on vitamin A and morbidity. The vitamin A project also provides technical review and guidance to private voluntary organizations (PVOs), whose grants are overseen by the Bureau for Food for Peace and Voluntary Assistance.

3. The project on "Food Technology for Development" performs research and development on the formulation and evaluation of low-cost, nutritious and palatable weaning foods for children. It helps countries shift from the use of imported PL 480 commodities to those that are available locally in developing countries. The Office of Nutrition works closely with the Bureau for Food for Peace and Voluntary Assistance in this area.

The Office of Nutrition continues its assigned technical leadership role within the Agency. As a result more and more A.I.D. units in Washington and in the field perceive how the inclusion of Nutrition strengthens their programs to overcome hunger and health deficiencies.

SANFORD COMMISSION REPORT

Mr. Hall: The recently-released Sanford Commission report on needs in Central America highlights the need for what they call "a comprehensive set of immediate actions in order to respond to the most pressing basic needs of Central Americans who face life-threatening conditions of poverty." The Commission proposes 2 billion dollars over three years for food security, health and nutrition, basic education, safe drinking water and sanitation, and a few other priority areas. Please detail AID's activities in this strife-torn region which are consistent with the Sanford Commission's recommendations.

Answer: It is important to note at the outset that the Commission in calling for increased assistance to Central America ($2.0 billion per year for five years up from $1.5 billion per year) recognized the large contribution that the U.S. has made to the region. Their recommendation is that the U.S. should "maintain current assistance levels and...increase cooperation with multilateral aid efforts."

With regard to your question, we are in full agreement that there are priority needs in education, health, sanitation etc. These are traditional areas of A.I.D. involvement and all of our assistance programs in Central America, to the degree applicable in each country, have on-going projects to address basic human needs. I believe you would find that A.I.D.'s entire development assistance portfolio in Central America is consistent with the recommendations of the Sanford Commission. However, these programs must go hand-in-hand with programs designed to encourage sustained growth or "immediate needs" will become chronic. A.I.D. programs in Central America, while recognizing the need to alleviate absolute poverty, are also encouraging the governments to implement sound economic policies and strengthening the private sector in order to stimulate broad-based economic growth. This growth will generate employment and increase income; in short, it will provide a larger pie to be divided among the population.

In addition to these urgent needs the Commission recommends that the U.S. cooperate with multilateral aid efforts and that, too, is being addressed. Last year World Bank Consultative Groups were formed for Costa Rica, Guatemala and Honduras. We participated actively in all three of these multi-donor meetings and continue to encourage the formation of a Consultative Group for El Salvador as well. The U.S. also joined in a U.N. consensus resolution which established the "Special Plan for Central America", being implemented by the U.N. Development Programme (UNDP). Although our resources will continue to flow through bilateral channels, we will continue to coordinate our efforts with those of the UNDP and other donors under the Special Plan.

PREPARED STATEMENT OF MRS. INGAR BRÜGGEMANN, REPRESENTATIVE OF THE DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

Mr Chairman, Ladies and Gentlemen.

1. INTRODUCTION

On behalf of the Director-General of the World Health Organization, Dr Hiroshi Nakajima, I have great pleasure in conveying to you and all members of the Select Committee on Hunger his greetings and his appreciation for inviting WHO to present its views. Dr Nakajima regrets that he cannot be with you personally today due to previous urgent commitments. He very much appreciates, however, the invitation conveyed to him, and he hopes that there will be other opportunities for him to be present at one of your hearings in the future.

The scope and content of the issue of "Improving Health of the Poor" before the Committee are of crucial importance for impact on the health and quality of life of millions of people worldwide. In more than one way it also is one of the main preoccupations and priorities of the World Health Organization's work and mission for the past 4 decades, and particularly so in more recent years, ever since WHO embarked on what is popularly known as "Health for All by the Year 2000." Tomorrow, April 7, World Health Day which will be observed all over the world, gives special significance to this hearing and we appreciate the Committee's decision to honor World Health Day by its discussion.

2. BRIEF OVERVIEW ON THE WORLD HEALTH SITUATION

Inspite of the recognition that health is an integral part of development, there is no denying that the health- and quality of-life gap between the developing and the industrialized world is widening rather than narrowing. Inspite of certain progress being made, there are still unacceptable inequities in health.

Socio-economic situation

Mr Chairman, today, a fifth of humanity -- that is over a billion people -- live below the poverty line, mostly in rural areas and urban slums. They are the victims of a vicious circle of unemployment and under-employment, economic poverty, scarcity of household goods, low level of education, poor housing, lack of water, poor sanitation, widespread malnutrition, high prevalence of communicable diseases, all of which cause social apathy leading to the lack of will and the initiative to make changes for the better. I am not referring to the kind of acute emergency situations often attract worldwide attention; I am referring to a permanent situation of deprivation to which the world remains largely oblivious.

Infant mortality

If we look at some recent health statistics: In 1987, 217 babies out of 1000 live births in Chad died before they were one year old, while in Sweden this figure was as low as 7 per 1000 live births. The rate of Chad is therefore 35 times higher than that of Sweden. The average for the 36 least developed countries was still at 140 and only at 12 for the 34 industrialized countries.

Life expectancy

Life expectancy which is closely related to infant mortality: people in the industrialized world have a life expectancy of about 73 years. In the least developed countries the average is still not more than 48 years.

Adult literacy rate

We are all familiar with the inverse correlation between infant mortality and adult literacy, particularly among women. I will not go into detail here about the complex question of cause and effect.

A comparison of figures between 1980 and 1985 showed that some progress has been achieved. In the least developed countries the percentage has risen from 28 percent in 1980 to only 34 percent in 1985. There is almost no need to mention the industrialized countries with their 98 percent for both periods. If it were not for shortage of time, it would be tempting to illustrate that the literacy percentages for women worldwide are consistently lower even today than that for men. As long as these disparities exist we are still far away from attaining universal social equity.

Maternal mortality

The widest disparity in all public health statistics is the number of women dying during pregnancy or when giving birth to a child. Behind the rather clinical words of "maternal mortality," the tragic death of about half a million women is hidden, who die every year from causes related to pregnancy and childbirth. Maternal mortality is among the leading causes of death for women of child-bearing age in most developing countries. Of the total of these 500 000 deaths all but 6000 take place in developing countries, which accounts for 99 percent of all maternal deaths. In the industrialized world there are not more than 10 women losing their lives out of 100 000. This figure can range from 300 to more than 600 in the third world.

The causes of these deaths are tragic indeed. They are deeply rooted in adverse social, cultural, political, and economic environment of societies, and often especially the environment that societies create for women. Women are discriminated against in terms of legal status, access to education, access to food and proper nutrition, access to appropriate employment, access to financial resources, and access to relevant health care, including family planning services. This discrimination begins at birth and continues through adolescence and adulthood, where women's contributions and roles are ignored and undervalued. Lack of access to any maternal health service, for example, results in the fact that in Africa only 36 percent of births are assisted by a trained health worker, not to forget the consequences of illegal abortion, which does not only lead to death but also to a high rate of being disabled. In fact, it is estimated that for every death that occurs due to pregnancy or childbirth, about 10 to 15 women are left handicapped in one way or another.

The toll of major diseases particularly in children under five

Communicable disease, fueled by low standards of environmental sanitation, inadequate socio-economic development and malnutrition, contribute to inordinately high levels of morbidity, mortality and disability in developing countries, they affect particularly children under five years of age. The mortality rate in children in the first year of life ranges from 100 to 200 per 1000 live births in most developing countries in contrast to rates of less than 10 to 20 per 1000 in the developed world. In the developing countries the incidence of vaccine-preventable diseases is still not good enough to avoid the significant effect on the morbidity and mortality caused by these diseases. It is estimated that vaccine-preventable diseases of childhood still kill some 4 million children each year and cause disability in 4 million more. In most developing countries diarrhoeal diseases represent the primary cause of child mortality. In the tropical belt these diseases may account for 15 to 40 percent of al deaths in children under five years of age. Acute respiratory infections also represent a major cause of mortality in children in developing countries and the leading cause of morbidity in children in all countries.

It is estimated that 56 percent of the world population lives in countries or areas where malaria continues to be a public health problem, leading to about 220 million cases of malaria infections per year. The disease kills children, particularly in Africa and to control the disease is hampered by the emergence of mosquitoes resistant to the more readily available insecticides.

You have already heard how, in the past few years, the development policies of many countries have been dominated by structural adjustment programmes made necessary by large debts and the servicing of those debts, aggravated by a downturn in the world economy. The measures taken have stressed the maintenance of growth through devaluation, export promotion and reduced public spending. As a result, government health budgets have contracted, sometimes dramatically. In one African country, over a 5-year period, the health budget was reduced by 50 percent. In another, spending on health fell from 5 percent of total government spending to 1 percent.

The effect on health of such decline is being seen in the recrudescence of tuberculosis, yellow fever and yaws and the resurgence of malaria. It was reported that, in one country in Africa, the percentage of hospital deaths from malnutrition increased from fewer than 15 percent in 1976 to 37 percent in 1987. In another country, 87 percent of mothers were found to be giving their children only one, or two, meals a day during the weaning period because there was not enough food available. the number of people living in absolute poverty is growing.

We are back in the vicious circle of poverty, malnutrition, diseases leaving people disabled, thus leading to further poverty.

Children and elderly persons are most vulnerable to conditions causing disability. Worldwide, it is estimated that between 340 and 480 million people are disabled as a consequence of mental, physical or sensory impairment. In the developing countries, the proportion of the population that is disabled is estimated to be as high as 20 percent. The absolute numbers of such affected persons is truly staggering. For example, WHO estimates that there are some 30 million persons who are blind, the vast majority of whom live in developing countries.

During the International Year of the Disabled Persons in 1981, the world community became aware of the opportunity that exists, through the application of already established and inexpensive technology, to intervene effectively against causes of disablement which afflict massive populations, for example, to prevent blindness or loss of hearing.

Endemic hunger and chronic malnutrition are other permanent conditions of a large number of people in many developing countries. It is estimated that about 40 million pre-school children in developing countries are living in conditions of acute malnutrition and more than three times that number is a chronic state of insufficient nutrition and associated illness that is hampering their growth and learning capacity.

Suddenly, to compound our long list problems, we are confronted with the problem of AIDS. It is less than ten years since scientists began to piece together the meaning of scattered observations of increases in hitherto rare disease. Since that time we have come to know a great deal, not only about the acquired immunodeficiency syndrome, but also about its causative agent, the human immunodeficiency virus. There is no precedent for discovering so much about a disease in such a short time. At this stage, 144 countries are reporting to WHO on their AIDS situation and have reported at least one case or more and the total number of cumulative cases reported is over 140 000. Even with concentrated efforts to improve reporting, it is felt that fewer than half the actual number of cases are being reported. It is estimated that, worldwide, there are at least 350 000 cases of AIDS and between 5 - 10 million persons are infected by the virus. It is quite clear that no country is immune to this disease, but only in the last two years has AIDS been thought of as a global problem. In the countries of Africa where AIDS is a problem, its adverse impact on development and on the economy is very serious indeed.

Crisis of financing health

The possibilities of increase in some communicable diseases is in no small measure related to the economic crisis many developing countries are faced with.

GNP and public expenditure on health per capita

Information on the public expenditure on health might conclude this list of gaps between the least developed and developed countries in relation to the gross national product.

In 1985, lest developed countries, with a GNP of $203 per capita spent only $4 on health, while the industrialized countries with a GNP of $10,150 per head spent $690. These figures need no comments (comparing $4 with almost $700, which still excludes all private financing) to tell the sad story of global health.

Political will

Mr Chairman, in pointing out these gaps, I wish to stress that ill health and lack of equity in access to health care as such is not merely an issue of the third world. These disparities and problems exist in the industrialized world as well. If these countries have succeeded in eliminating the major infectious diseases, they are now faced with a series of chronic and mental diseases, diseases caused by environmental and social hazards, diseases caused by unhealthy lifestyles, like overeating, overdrinking, heavy smoking, drug-addiction, "over driving" leading to accidents, and careless behaviour leading to AIDS infection.

In addition, in any of the so-called "developed" countries, there are regional or social pockets of the population, whose situation comes very close to the picture drawn for the developing world, at least in relation to diseases and deaths caused by poverty and ignorance.

And yet, health is a basic human right of all people and peoples. This means that the complexity and multifactoral nature of ill health calls for political determination, clear strategic decisions, bold and innovative programmes, and, last but not least, resources; human institutional and financial resources in any country of this globe.

3. HEALTH - A CORNERSTONE FOR DEVELOPMENT

Mr Chairman, for over 4 decades it has been the main mission and work of the World Health Organization to confront these odds, challenge the world conscience and to espouse the cause through a worldwide movement, popularly known as Health for All by the Year 2000.

WHO's role in health development

Experience in WHO over decades has shown clearly that health and development are intrinsic in nature. A mere channeling of financial resources, however, has proved to be futile and counter productive. Health as a cornerstone in human and socio-economic development requires individual involvement, community action, national health polices and programmes leading to a self-reliant, well-managed health system. International cooperation and scientific technical and financial support have to help strengthen such national capacities in a sense of genuine partnership - which goes beyond ad hoc acts of charity. WHO, therefore, appreciates this dialogue with you, as representatives of a country which, since the inception of WHO, and as one of its founding fathers, have been strong supporters of WHO and its policies and programmes.

Mr Chairman, tomorrow is the 7th of April. The birth certificate of WHO, that is its Constitution, drawn up by the founding Member States, including the United States, more than 40 years ago, is surprisingly valid and inspiring today as when it was first formulated. It calls for health as one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition. Furthermore, it states that "The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States." The lack of access to health that we have recognized and the imbalance in socio-economic development are surely not conducive to world peace.

4. WHO's MANDATE: HEALTH FOR ALL BY THE YEAR 2000 AND BEYOND

The mandate of governments that have committed themselves to the Constitution of WHO is very clear: improved health of all peoples, including the poor, and this should be the responsibility of individuals, communities and states, be it in their own countries, or -- as in the case of the concern of this Committee -- in a country's response to the need of other countries whose resources are too limited to achieve better health for all their citizens.

In the forty years that elapsed since the foundation of WHO, these demands have guided WHO's mission as the directing and coordinating agency for international health.

Where does WHO stand today, particularly vis à vis the Committee's concern in improving the health of the poor? What are the action plans towards health needs of those who, at this stage, forego the right to have access to the basic provisions that would allow them to lead a healthy life and permit them to be socially and economically productive?

These are the very words that define the goal set by WHO's Member States when they decided in 1977 that attainment of health should be the main social target of Governments and of WHO.

This expression of WHO's objective became popularly known as "Health for All by the Year 2000." You will recall how, in 1978 in Alma Ata, USSR, at the International conference on Primary Health Care sponsored jointly by UNICEF and WHO, more than 130 countries agreed that Primary Health Care is the key to attaining this target.

In the Declaration of Alma Ata, eight essential elements were defined as the minimum requirement of primary health care that should be available to everyone. In view of their particular relevance for improving the health of everyone and most surely of the poor, I would like to enumerate them briefly:

1. Access to information and education concerning prevailing health problems and on the methods of preventing and controlling them;

2. Promotion of food supply and proper nutrition;

3. Adequate supply of safe drinking water and basic sanitation;

4. Maternal and child health care, including family planning (trained personnel for attending pregnancy and childbirth, and caring for children up to at least 1 year of age;)

5. Immunization against the major infectious diseases; (diphtheria, tetanus, whooping-cough, measles, poliomyelitis and tuberculosis;)

6. Prevention and control of locally endemic diseases;

7. Appropriate treatment of common diseases and injuries; (local health care within one hour's walk or travel;)

8. Provision of essential drugs (availability of at least 20 essential drugs within one hour's walk or travel.)

Mr Chairman, the provision of a minimal essential package of primary health care outlined above is at the very heart of international cooperation for eradication of world hunger and its effects.

Progress achieved

The evaluation of the first ten years after Alma Ata, which Member States of WHO undertook, showed that life expectancy had indeed increased and infant and maternal mortalities have declined in a global sense. Even the number of countries with very high infant mortality has fallen almost by half between 1960 and 1985. However, as shown earlier, such statistics can easily disguise the difference that exists between regions and countries of the world and also between different parts of any one country.

The evaluation and constant monitoring of national progress is based on 12 specific indicators, which proved to be of relevance on a global scale and it is not by chance that the first of these 12 indicators measures the Attainment of the highest level of political commitment to equity in health.

Yet, there is clear evidence in the evaluation that the mere concept of setting specific targets for health, particularly if set by Member States themselves, and supported by a strong political will as well as by the international support, improvement in health can be achieved.

Take for example the target of immunizing 100 percent of all children by 1990 jointly aimed at by governments, UNICEF, WHO and many others like Rotary International. True, in 1988, we only got halfway through the target but who would have believed some ten years ago -- when only 5 percent of the children in developing countries were vaccinated -- that in 1988, at lest 50 percent would have been reached?

We are here to decide on how to do better, since the monitoring and evaluation process had also clearly shown the factors impeding greater progress in health development and improved health status. Some of these factors are:

- continuing high population growth;
- low female literacy;
- growing urbanization;
- economic constraints and deteriorating socio-economic conditions in many developing countries;
- weak management of resources; and
- inadequate application of science and technology.

The reported results also indicate lack of progress in reducing social inequity in health. As Dr Hiroshi Nakajima, Director-General of WHO, recently said: "... as much as good health of a nation will contribute to its socio-economic development, so will the socio-economic development of a country contribute to the health of its people. As long as there remains an imbalance in socio-economic development in different parts of the world, and access to health is not equitable, the tensions that result will not be conducive to world peace."

5. BILATERAL AND MULTILATERAL SUPPORT TO HEALTH AND TO WHO

The positive experience of now more than 40 years of collaborating with Member States, with lateral agencies such as US AID, other intergovernmental bodies like UNICEF, UNDP, World Bank, etc., speaks for itself. WHO, as you well know, in a technical organization, it is not a fund for health. It is challenged to help in the appropriate use of resources that you as government spend on health in your own countries, or in support of others. I cannot but remind you how the development of appropriate technology in the context of smallpox eradication, - one of the success stories in the field of public health, - and a feasible and manageable approach worked out by technical experts, led to the eradication at the cost of only $300 million over a period of 10 years. It has been calculated that the savings made every year by not having to vaccinate amount to $1 billion in the industrialized countries alone. (About $300 million in the U.S. alone.)

Thus, WHO is grateful for the continuous support it has received from the United States government, its aid agencies, scientists, research centres and individuals.

You have already heard how collaboration has paid dividends in the achievements made in joint efforts in fields such as immunization; control of diarrhoeal diseases; fight against malnutrition; the Global Combat Against AIDS; the strengthening of national health systems; the provision of essential drugs.

CONCLUSION

Mr Chairman,

Let me summarize: WHO will pursue its mandate of improving access to a better health for everyone through Primary Health Care. It recognizes the new challenges that have emerged since Alma Ata: the complex problem of AIDS, the increasing environmental hazards, the declining resources for health care, and the research needs for improved appropriate technologies.

It is recognized that health as development cornerstone requires long-term constant national and international support. To seek and maintain equity in health, governments, bilateral and multilateral aid agencies, nongovernmental organizations, and the private sector need to cooperate and coordinate their support to national plans and programmes.

Health development requires world solidarity, political commitment; involvement of individuals, communities, non governmental organizations and the private sector. It calls for intersectoral action; it needs training of health manpower to local conditions; the use of appropriate technology, and optimum use and management of all resources available for health (human material, technological and financial.)

Support in the context of improving health of the poor is required to fight malnutrition, high infant mortality under five and mothers dying in childbirth. Practical solutions are at hand. This calls for support on an unprecedented scale.

Mr Chairman, my final thought is in relation to the work and concern of your Committee.

In the perspective of global health issues that I just outlined, we believe that the Health for All strategies and programmes derived from them and the additional challenges mentioned, have taken deep roots in almost all the countries of WHO's Member States. Apart from the developing countries, who are the main focus for the fundamental thrust of these strategies, even industrialized countries particularly in Europe, have greatly benefited by appropriate adaptation of the Primary Health Care approach leading to their health promotion initiatives, based on very specific targets. In the context of these positive developments, it is more than ever necessary for your Committee, the U.S. Congress, and the U.S. Administration to yet further strengthen their role and leadership in international health cooperation. Such a process in practical terms will mean working with multilateral developmental institutions and organizations such as WHO and UNICEF to accelerate on the one hand formulation of rational health policies and programmes and enhancing through USAID and other partners the translation of these technical cooperative programmes in key areas of health development. Indeed we see no other short cuts to these complex problems.

Mr Chairman, the Director-General has asked me to reassure you that WHO stands ready to work with you towards this end.

Thank you.

PREPARED STATEMENT OF JAMES P. GRANT, EXECUTIVE DIRECTOR, UNITED NATIONS CHILDREN'S FUND

Introduction

Mr. Chairman and distinguished Members, it is a great pleasure to appear this morning before such a supportive and encouraging body to report on the major advances of the child survival and development program which bears much evidence of your leadership and kindness. Your ever-present focus and concern regarding the most vulnerable among us both in the United States and in the developing world, has been of great value to our joint mission on behalf of the mothers and children of the world. We owe you many, many thanks. Your's is indeed a Select Committee!

On the subject of partnership and collaboration, I must say that it is particularly enjoyable to share this witness table today with colleagues who are among the pioneers and engineers of the peaceful revolution that will lead us to Universal Childhood Immunization by 1990 and Health for All by 2000. UNICEF and the World Health Organization are, of course sister agencies united by much common ground and collaboration in the expansion of primary health care. AID and UNICEF have worked side-by-side in scores of developing countries laying the track for the twin engines of our program, immunization and oral rehydration therapy. Bill Foege and the Task Force for Child Survival have provided our growing alliance of leaders concerned about children with a forum through which we can survey our progress and reaffirm our strategies.

And Rotary International is the very personification of social mobilization. Rotarians around the world have proven that tough goals can be met and even surpassed when the lives of children are at stake. Five years ago Rotary pledged to raise $120 million toward the eradication of polio by 2000. No simple task. Well, the tally now stands at close to twice that amount, $230 million and still rising. Polio will be eradicated by the year 2000, and millions of tomorrow's children will owe their health to Rotary.

The State of the World's Children, 1989

Mr. Chairman, there are a number of timely matters I would like to raise with the Committee today, most notably our progress in the Sudan, prospects for a Summit on Children, and our recent discussions at the Paris Roundtable. However, I believe it of enormous importance to this review of the international health and child survival program to discuss at the outset the context in which we are all working and which threatens to undermine our gains. I am referring, of course, to the $1.3 trillion external debt problem of the developing world which has derailed the march of human progress for almost nine hundred million people, approximately one-sixth of mankind.

As we have sadly reported in the 1989 edition of The State of the World's Children, the young of the world's poorest countries are bearing the heaviest burden of debt and recession in the 1980's. The social statistics now available reveal in hard numbers the human impact of the macro-economic drama that has tragically led to a $20 billion negative financial flow from the southern world to the northern hemisphere. This haemorrhaging, occurring mostly in Latin America and Africa, must be tabulated not just on financial balance sheets, but in terms of declining health, education, and loss of life.

Throughout most of Africa and much of Latin America, average incomes have fallen by 10% to 25% during the 1980's. The average weight-for-age of young children is falling in many of the countries for which figures are available. In the 37 poorest nations, spending per head on health has been reduced by 50%, and on education by 25%, over the last few years. And, in almost half of the 103 developing countries from which recent information is available, the proportion of 6-to-11 year olds enrolled in primary school is now declining. Tragically, UNICEF estimates that at least half a million young children have died in the last twelve months as a result of the slowing down or reversal of progress in the developing world.

Mr. Chairman, these figures are vivid signs of decline in human investment, caused by the deadly combination of rising debt repayments and falling commodity prices, which will have an impact on the people of the developing world for many years to come - debt relief prospects notwithstanding. The investment in human capital, in the nutritional status, basic education, and health cannot be postponed in the case of children and must occur when the need is present. As we note in The State of the World's Children, there is no second chance for the young child. The real tragedy of the crisis, of the disinvestment in human capital in the 1980's, is that its results will be observed in the stunted bodies and under-educated backgrounds of many adults living into the middle of the 21st century.

Solutions and Priorities

Mr. Chairman, I think we all agree that the principal solution to the overall financial crisis lies in some form of debt relief and a return to economic growth. The need for adjustment is not in question either. However, the essence of UNICEF's position, as summed up in our recent publication Adjustment with a Human Face, is that policies which lead to rising malnutrition, declining health services, and falling school enrollment are inhuman, unnecessary, and ultimately uneconomic. Conversely, policies which seek to protect the poorest families and their children - for example by maintaining well-targetted food subsidies, expanding primary health care services, and consolidating gains in primary schooling - represent both a short-term human imperative and a long-term economic investment. We can emphatically answer "No!" to Tanzanian President Nyerere's anguished plea when he stated "Must we starve our children to pay our debts?".

Major changes in this tragic situation will only follow from a reorientation of response at three levels. First, there is a need for a fundamental change in *perspective*. A recognition that the protection of basic needs of people is an urgent priority as the basis for long-term economic progress in developing countries and as a basis for a more stable and democratic world. *Human* development must be more actively promoted by bilateral and international institutions and by the developing countries.

Second, there is a need for *action*. Donor countries and institutions, as well as national development plans must specifically give priority to human development and protection of basic human needs in the course of adjustment. There already has been welcome recognition of this by the main international financial insitutions and by a number of donor countries. But this recognition must be followed by accelerated support and practical action. One example of such action, UNICEF has dubbed "Debt Relief for Child Survival", a scheme in which banks or donor governments are invited to "swap" their debt in exchange for domestically financed programmes of child development, implemented in cooperation with UNICEF. A recent example of this debt relief arrangement involving the Midlands Bank will give a number of villages in the Sudan access to clean drinking water and provide support for health and reforestation.

Thirdly, the monitoring of the process of recovery and development needs to give more attention to human indicators, in addition to the conventional range of financial and economic indicators. We need to be concerned with rates of nutrition as well as rates of inflation; with imbalances not merely of payments; with the provision of shelter for people and not merely with the provision of reserves to cover future import needs. These elements are not only humanitarian priorities, but fundamental for restoring rapid and solid economic growth.

Achievements of the 1980's

Mr. Chairman, lest I give the impression that the debt vortex has swallowed whole all the progress we have achieved through the child survival and development programme, I would like to turn to our accomplishments. The seeds we have sown together over the last six years have borne plenty. If you recall, in 1982 UNICEF articulated what we described as "New Hope in Dark Times" - the possibility of a virtual revolution in child survival and development, accomplishable at low financial cost even in economically difficult times - if only governments and national leaderships could marshall the political will to try.

Our proposition was simple: that the then annual toll of some 15 million child deaths could be halved within 10-15 years through the effective mobilization in all countries of today's communications capacity to empower the vast majority of families with knowledge of low-cost techniques - the GOBI group. I am happy and proud to report that this new hope has led to real results. At the beginning of this decade, immunization coverage of children in the developing world was less than ten per cent; vaccine-preventable diseases were claiming approximately 4.5 million young lives each year. But in the last five years, as the Child Survival and Development

Revolution (CSDR) has gained momentum, vaccine use has trebled and quadrupled as more than 100 nations have begun to accelerate their immunization programmes towards the United nations goal of Universal Child Immunization by 1990 (UCI 1990). Immunization coverage in the developing world has risen to approximately 50%. Twenty-five developing countries have reached coverage of 80% (for under-ones) against all six leading child-killing and crippling diseases. As a result of these accelerated efforts, vaccines are now preventing over 1.5 million more child deaths each year in the developing world.

There is similar progress to report in the spread of oral rehydration therapy. The dehydration associated with diarrheal diseases remains the single greatest killer of children in the modern world. As this decade began, only two or three percent of the world's parents were empowered to use - or even knew about and knew how to use - ORT, which had been invented only in the late 1960's. In 1980, dehydration caused by diarrhoea was claiming almost 10,000 young lives every single day. Today, WHO estimates that the parents of approximately 50 percent of children under five years have access to oral rehydration salts (ORS), including access to a trained health worker who can demonstrate proper use. More than 25 percent of the developing world's families are now using the low-cost technique.

The result is the saving of an estimated 750,000 to 1 million children's lives each year.

Mr. Chairman, equally significant for the cause of maternal and child health is the rapid spread, during the 1980's of knowledge about birth spacing. As you know, births which are 'too many or too close', or to women who are 'too old or too young', are responsible for up to one quarter of all _maternal and infant_ deaths worldwide. The promotion of birth spacing to the point where a majority of couples in the developing world now have the knowledge to decide the number and timing of their births is therefore a major breakthrough.

The relationship between declining child death rates and subsequent declines in birth rates should be of particular interest to the Members of the Committee. As we note in _The State of the World's Children_ report, fertility rates have fallen in almost all regions of the world over the last 20 years and are now beginning to turn downwards in Africa. Although the reasons for this are many and complex, history has shown that no significant decline in birth rates has occurred without being _preceded_ by a similarly significant decline in child death rates. The past 40 years of Japanese history are a prime example of this relationship. The empowerment of parents with the knowledge to improve the well-being of their children increases their confidence that all their children will survive and it is this confidence leads to a decrease in the family size.

In sum, I am pleased to report on this score that with your encouragement and support, we continue to spread the access and delivery of the child survival and development revolution to more and more communities and families every day. Although a great deal is yet to be done, particularly on ORT which has lagged somewhat behind EPI, the goal of Universal Childhood Immunization by 1990 is within reach. We are all prepared to stretch!

The Bamako Initiative

Mr. Chairman, while UNICEF is on the one hand hard at work spreading the availability of immunizations and primary health care to increasing numbers of people, it is on the other devoting considerable attention to the issue of sustainability. Closely linked with the sustainability question are matters such as financing and cost-recovery, which can be crucial given the economic climate in which we find ourselves. These matters have taken on particular importance in Africa where many governments are today unable to provide the essential drugs, medical supplies, transport, fuel and money needed by the 'front line' health services. However, we believe they are critical to the prospects of reaching the Health for All by 2000 goal in all regions of the world. Toward this end, UNICEF has successfully promoted the testing by sub-Saharan African nations of community financed and managed primary health care systems which are maintained by the proceeds from selling essential drugs. More than 20 African nations are developing plans for what has become known as the 'Bamako Intiative' (so named following its adoption by the African Health Ministers in Bamako, Mali, in 1987).

The mainspring of the Bamako Initiative is the idea of decentralized, self-sustaining primary health care fueled by the willingness of most people to pay modest amounts for medicines. Our experience has shown that most people already pay too much for drugs which are either inappropriate or of poor quality. The Bamako Initiative therefore aims to provide a steady supply of essential drugs which can be sold at modest cost by village health workers at prices high enough to replenish the drugs and produce a reserve for the community to spend on health. But the aim is more than essential drug supply: it is to strengthen and extend maternal and child health care and to promote community involvement in decisions about local health priorities. Responsibility for deciding how the money is spent rests with the village health committee.

The Grand Alliance

The synergism created by the specific child survival interventions, however, cannot be measured by statistics alone. There has emerged from the social mobilization aspect of the experience a surge in public concern for children in both industrialized and developing countries. This concern has led to a broad-based alliance among political leaders, the press, professional organizations, international and private voluntary organizations involved in the effort. This "grand alliance" includes the hundreds of thousands of schoolteachers, trade union and cooperative leaders, religious leaders, employers, community organizations, writers, artists, and entertainers, and the political parties and parliamentarians such as yourselves who have promoted the child survival initiative. The vastness of this group of influential champions and the general agreement among us of the worth and impact of the CSDR holds out the promise of even more significant progress in the 1990's.

Evidence of the prominence of the Grand Alliance and the new ethos for children is plentiful in the past several years. As the Committee may know, the Joint Statement issued on June 2, 1988, following the Moscow Summit meeting between President Reagan and General-Secretary Gorbachev included as its only social issue a call for accelerated worldwide action to reduce childhood deaths from preventable causes.

The Joint Statement reads:

> Both leaders reaffirmed their support for the WHO/UNICEF goal of reducing the scale of preventable childhood deaths through the most effective methods of saving children. They urged other countries and the international community to intensify efforts to achieve this goal.

Mr. Chairman, it seems that UNICEF and the child survival program has been on a unique "roll" for the last two and one half years. Scarcely one week before the issuance of the Joint Summit statement, the 51 member Organization of African Unity adopted several resolutions endorsing child survival efforts, including UCI 1990. Several months before the OAU meeting, the

Task Force for Child Survival, also known as the Bellagio Group, met in Talloires, France, to review the major child health achievements of the 1980's and the major problems of the 1990's. As you recall, this group includes the heads of UNICEF, the World Health Organization, the United Nations Development Programme, the World Bank, and the Rockefeller Foundation. Together with the Ministers of Health from many developing countries (representing a majority of the world's children) and the leaders of most major aid agencies, the Task Force concluded that, despite the shadow of AIDS:

> remarkable health progress has been achieved during the past decade...Global recognition that healthy children and healthy families are essential for human and national development is steadily increasing.

The Talloires Declaration is a fine example of the tremendous conformity and unity that has developed on these matters of great importance to the children of the world and it was a nice shot in the arm, pun intended.

The seven South Asian Association for Regional Cooperation

(SAARC) countries and the seven Central American countries also have at their respective summits debated the specifics of the survival, protection, and development of children. Clearly, the issues which concern all of us in this room have come of age.

The Convention on the Rights of the Child

Mr. Chairman, ten years ago, in 1979 when the world celebrated the International Year of the Child and the 20th anniversary of the Declaration on the Rights of the Child, UNICEF argued that the year should mark "not a high point but an inflection point" in the graph of concern for children. As you can see, given the above examples, we have had some luck in directing that point ever upward. This year, in 1989 I can scarcely think of a more important vehicle to help us and other organizations continue making our case before governments and the international community than the future International Convention on the Rights of the Child.

Children have no specific body of international law that establishes and defines standards for their protection, survival, and development. Largely, they are dependent on their parents, governments, or guardians to act in their best interests and to protect their rights. However, for many children in the world today, that protection is manifestly not enough. Millions of boys and girls are physically or sexually abused, or economically exploited. Children are denied their rights by forces beyond the family's control - by war and natural disaster, by unemployment, poverty,and their parent's lack of education. In our times, governments are still recruiting children to fight wars, employers are still exploiting the children of the desperately poor in fields and factories. As we have reported with regard to the debt crisis, national and international economic forces are still able to inflict permanent mental and physical damage on young children who, no matter what the external circumstances, have a special right to protection for their growing minds and bodies. Herein lies the value of the Convention. It is the codification of the broad social and legislative consensus on what is and is not acceptable in the treatment of the young. The Convention addresses the child's economic, social, cultural, political, and civil rights and defines the obligations of adults toward children.

Over the past ten years, representatives of over forty governments, including the United States, have been meeting regularly as a subset of the UN Human Rights Commission to draft the Convention. I am pleased to report today that a consensus has emerged from these sessions regarding almost all key provisions of the law and the prospects are very good that it will be adopted by the General Assembly of the UN by December of 1989.

These prospects were very recently buoyed following the unanimous adoption of a resolution in support of the Convention by over 500 parliamentarian members of the International Parliamentary Union meeting at its Centennial Conference in Budapest. Incidentally, the theme of the entire conference marking the 100th anniversary of the founding of the IPU was the Protection of Children.

Summit for Children

Mr. Chairman, as I have indicated in The State of the World's Children, I believe that the time is ripe for us to give serious consideration to a meeting of heads of State in order to discuss and prepare for action on the great opportunities now available for protecting today's children and tomorrow's world. In addition to its specific agenda, such a meeting might also help to bring the subject of children to the very center of political and economic concern.

Such a summit for children might also help to bring political leaders together cooperatively on common ground, facing the common direction of our common future. Specifically, I have suggested the overall theme of "Today's Children - Tomorrow's World" to focus attention on the convergence of sectoral problems in their human impact and offer also the ten, twenty, or thirty year depth of field which the great issues of environment and poverty so clearly demand.

Finally, I believe such a summit would be instrumental toward increasing and accelerating actions for children within perhaps all countries by placing the world spotlight on the possibilities. The very occurrence of a Summit for Children would be so extraordinary and unusual it would be of enormous consciousness-raising value causing governments, private organizations and individuals, the business sector, media, and the public at large to focus in on their own community's and country's response to the needs of children. This kind of awareness could generate the political and popular momentum we need to extend what we have learned in child survival to all children.

On this subject I am pleased to report that 22 Governments have now explicitly indicated support for a world Summit on Children. And I would like to express my thanks to the Chairman and Ranking Member of this International Task Force for their endorsement of the Summit proposal. Your Congressional Resolution is very much appreciated and I trust will be noted by parliamentarians and governments throughout the world.

Children on the Front Line

Mr. Chairman, I would like to conclude my statement with a discussion of two particularly timely topics - literally topics of the hour. The first, the release just two days ago in Harare, Zimbabwe, of Children on the Front Line which highlights the effects of apartheid, destabilization, and warfare on the children of the southern Africa. The second, "Operation Lifeline Sudan" from which has emerged an extraordinary agreement between government and rebel forces.

When Children on the Front Line was first released in 1987, it sounded an alarm heard round the world regarding the appalling conditions which have prevailed in southern Africa in the 1980's. We reported that the conflict had increased Angola's and Mozambique's infant mortality rates to among the highest in the world. I am sad to report today that the suffering not only persists, it has become worse.

In southern Africa, twenty-five children are dying every hour from these causes. More than one million lives have been lost during the past eight years. At least as many children died in 1988 as in 1986, when figures were first gathered for this report series. Of the 1.3 million lives lost during the past eight years, 850,000 have been children under five. In 1988 alone, 147,000 young Angolans and Mozambicans have died who would have lived, if not for destabilization and war. As the report states:

> By 1988, the number of Angolan and Mozambican children under the age of five whose lives were lost as a consequence of war and destabilization totalled more people than were killed by atomic bombs in Hiroshima and Nagasaki. The toll is still rising and will not fall until the conflict has ceased.

Mozambique has suffered the loss of at least 1 million refugees, and Angola half a million. Of these almost half are under 15 and about three quarters are women and children.

The infant mortality and under-five mortality rates in Mozambique and Angola remain among the highest in the world. In 1987, for every 1,000 children born in these countries, 325-375 children younger than five died.

The wars in Angola and Mozambique have resulted in the wholesale destruction of health and education facilities. By the end of 1987, 20 percent of health facilities in Mozambique had been destroyed outright and hundreds of medical personnel wounded or maimed. 36 per cent of primary schools had been destroyed or abandoned. Figures for Angola are less complete, but it is known that at least 10,000 people were mutilated in 1985, while the delivery of health services declined by 30 percent throughout the country. Countless health workers have been killed, maimed, wounded, or kidnapped. The result of all of this is that easily preventable diseases are now taking a rising toll on the vulnerable age group of infants and children under five.

There is great need for action on behalf of these children throughout the region. But this action is needed far beyond the health sector alone. Of critical importance is the re-establishment of food security and agricultural development as soon as possible. UNICEF is supporting such efforts, especially in Mozambique. Transport and fuel security have been identified as most basic, particularly in Angola and Mozambique. The report states that "unless transport to southern African ports can be guaranteed, no other security is possible."

The news with regard to the situation of black children in Namibia is almost as dire, except that the occupation of that country is coming to a close and UNICEF is now establishing an office and transition programme for child survival and development. Infant mortality for black Namibians in the capital, Winhoek, is 175 per 1000, and under five mortality is 235. IMR estimates for the country as a whole are 200 plus (white babies) and 300 plus (black babies), respectively.

Operation Lifeline Sudan

Mr. Chairman, as you may know, the UN Secretary General Javier Perez de Cuellar has appointed me to be his personal representative for coordinating the mobilization of international support for "Operation Lifeline Sudan". This operation is essentially a race against time to help as many as 2.5 million people in this war-torn country. The operation will seek to urgently procure and preposition food and supplies to the over one million people in immediate danger of starvation and in need of emergency assistance in regions affected by the war. Although the conflict has created this emergency, however, it is the approaching onset of heavy seasonal rains that has made implementation of the "Plan of Action" within six weeks of life and death importance. Beginning as early as the first week in May, the rains will literally seal many areas off to outside assistance.

This historic Plan of Action, including an essential "month of tranquility" proposed by the Secretary General, has been unanimously adopted by all the participants of a high-level meeting convened jointly by the Secretary General and and Prime Minister of Sudan on March 8 and 9. The participants of the Khartoum meeting included representatives of donor governments (including Julia Taft of AID's Office of Foreign Disaster Assistance), United Nations agencies, and national and international NGOs. The "corridors of peace" part of the Plan assuring safe passage of relief convoys was subsequently approved by the SPLA in the course of my meeting with its officials in Addis Ababa.

Mr. Chairman, the Plan, perhaps more appropriately called the challenge calls for expansion of activities on the part of

UNICEF in SPLA-held and Government controlled areas in order to facilitate the implementation of the emergency relief program, particularly in the health sector, to monitor distribution of emergency commodities and provide an umbrella for NGO activities. There will be eight "Corridors of Peace" through which relief supplies will be channelled. In accordance with the Plan, ten monitors will be posted in the field to ensure that food is delivered to those in need. Five monitors will be UNICEF representatives and five will be World Food Program representatives.

Needless to say, the foundation of the Plan is universal recognition on the part of the parties involved of the complete neutrality of the humanitarian relief effort. Of course the crucial part of the plan is delivery of assistance - and that I am pleased to say has begun. Every means is will be used to ensure rapid transport of supplies to targetted areas.

A final word on this, Mr.Chairman. The United Nations has just launched a system-wide Appeal for $55 million in additional funds to carry out the operation.

Thank you, I would be happy to answer your questions.

Fein

PREPARED STATEMENT OF WILLIAM H. FOEGE, M.D., EXECUTIVE DIRECTOR, TASK FORCE FOR CHILD SURVIVAL

Mr. Chairman and Members of the Committee:

I am William H. Foege, Executive Director of The Task Force for Child Survival. I am pleased to be able to present to you activities of The Task Force for Child Survival, and our perception of the opportunities that remain.

I. INTRODUCTION

When I addressed you in 1985, you heard that in March 1984, thirty-four (34) world leaders participated in a conference sponsored by The Rockefeller Foundation in Bellagio, Italy, to consider the subject of better protecting the health of the world's children. At that meeting, the formation of The Task Force for Child Survival was proposed and endorsed, with the specific objective of improving immunization levels of children in the developing world. That role has been slightly expanded over time so that now we also concern ourselves more broadly with child health.

The Task Force consists of representatives from The World Health Organization (WHO); United Nations Children's Fund (UNICEF); The World Bank; The United Nations Development Programme (UNDP), and The Rockefeller Foundation. The Task

Force has a small staff, located in Atlanta, Georgia, that is housed in The Carter Presidential Center.

The current role for The Task Force is best illustrated by the International Child Survival meeting held in Talloires, France, in March of last year. This meeting followed the pattern of previous meetings held in Bellagio (1984) and Cartegena (1985). Representatives from 13 countries of the developing world joined technical experts from WHO, UNICEF, UNDP, The World Bank, and The Rockefeller Foundation; senior representatives of several bilateral government agencies; and non-governmental organizations (NGOs) and representatives of The Task Force for Child Survival.

In addition to reviewing the status of progress towards achieving the Universal Childhood Immunization objectives for the year 1990, this conference explored the status of efforts to impact on morbidity and mortality of diarrheal diseases and the role of family planning in enhancing the chances of a child to survive into adulthood.

One of the products of this meeting is the so-called Declaration of Talloires, issued by the sponsors of The Task Force for Child Survival. In it, bold new initiatives are suggested as being possible with today's technology, commitment, and skills. These objectives for the year 2000 are not simply dreams. They are achievable within the known capacity in the world.

A copy of the Declaration is being provided to you. You will note that the eradication of poliomyelitis by the year 2000 is among these targets. Two months after our meeting, the World Health Assembly officially resolved to pursue that objective. In the Americas, we expect that polio will no longer be transmitted after 1995.

At this time, I would like to review what has been accomplished in child survival, review unfinished work, and look at the future.

II. ACCOMPLISHMENTS

The materials that will be presented are mainly based on analyses of data cited in UNICEF's The State of the World's Children, 1988.[1] The major sources of these data are the United Nations Population Division, the World Health Organization, The World Bank, and UNICEF. In addition, United Nations Population Division sources[2] were used for populations for countries in the years 1960 and 2000. Future trends in life expectancy and birth rates were obtained or derived from World Bank estimates.[3]

Standing even at a vantage point in 1960, we would have been unprepared for the health improvements which were about to unfold over the next 25 years.

The drop in Infant Mortality Rates (IMRs) since 1960 is astounding. In every IMR range, there have been significant declines. Countries with IMR's in excess of 200 per 1,000 live births in 1960 averaged 140 in 1986. Countries that averaged 60 dropped to 25. One can be pleased by the decreases across the board; and yet this figure hides a truth.

The truth is that the percentage drop is greatest for those countries that already had an advantage. The lower the range of a country's infant mortality rate in 1960, the higher the average percentage drop in infant mortality in the next decades. Indeed, 1960 IMRs can be used to predict what would happen over the next quarter of a century for infant mortality and crude birth rates.

The global IMR, a rate not often used, has dropped from 127 per 1,000 live births in 1960, to 72 in 1986, a drop of 55 deaths per 1,000 live births. Figure 1 compares IMRs to the Gross National Product (GNP) in the United States in this century from 1960 to the present. It also shows the rate of decline of IMRs for developing countries from 1960 to 1986. The rates of decline are similar to the rate of the U.S.

decline, and in some specific countries much faster. But the encouraging point is that these declines in developing countries are seen with GNP's that are lower than were seen in the U.S. even at the beginning of the century. It is possible to lower infant mortality even before there is a marked improvement in wealth.

This global decline translates to over 7 million children who will not die this year because we no longer have the infant mortality rates of 1960 (Figure 2).

As deaths have gone down, births have not decreased proportionately, and we must worry about the continuing increase in the population. This is an appropriate reason for worry; and yet there are some hopeful indicators. Infant mortality rates in 1960 also become predictors of what would happen to crude birth rates in the next decades (Figure 3). We have known for some time that countries with lower infant mortality rates also had lower birth rates. This seemed to be a logical coexistence for populations with higher literacy rates, development, etc. But Figure 3 gives an additional perspective to this relationship. It shows that the ranges of countries' IMRs in 1960 were predictors of what would happen to birth rates over the next quarter century; the lower the baseline IMR range, the more rapid the decline in crude birth rates. We have been unable to find any previous reports describing this predictive relationship, which provides evidence that child survival programs can, indeed, be powerful in influencing population growth in the future and provides support for the notion that the successful implementation of interventions that reduce infant mortality rates will lead to accelerating declines in both IMR and CBR.

The problems of population growth and environmental degradation constitute one of the major issues of our time. A priority must be given to family planning and population control. However, it must be clear that child survival programs contribute to a solution of that problem.

One bottom line, in all of this, is the continuing reduction in the risk of losing a child (Figure 4). This is not just a result of smaller families, but there is a decreased risk with each child. Based on under 5 mortality rates in 1960, a family with 3 children had about a 50% chance of losing 1 or more children. This risk had been cut in half by 1986.

III. REMAINING PROBLEMS

The changes have been better than we generally realize, but formidable barriers remain. Low birth weights continue to be a significant problem in both developing countries and in the United States. The same countries with high rates of deaths in children also have high rates of maternal mortality. The fact that it is not surprising does not detract from its tragedy. These are problems which correlate with insufficient health personnel, unequal treatment of women and lack of education for women.

All countries suffer from the lack of sustained world support. Those of us from the United States are especially embarrassed by hardships caused in recent years by our failure to pay our WHO assessment. All countries fall short of providing sufficient managerial abilities, and we all miss possibilities in educating both medical workers and the public.

The current suggestion that the United States contribution to UNICEF will be reduced for 1990 is an error that must be corrected. UNICEF has suceeded in making child survival a rallying point for societies in many countries. Not only are the needs for financial support for programs and activities continuing, it also is one of the better investments that the United States can make.

Like the contribution to WHO, the United States must continue to demonstrate that it is willing to remain the leader in the area of global efforts to insure child survival.

We also are joined in facing the problems now imposed by AIDS.

On a global basis, it is assumed that 90% of infants infected at birth will die within 5 years, 25% in infancy and 65% from 1-5 years, and that 40% of infected pregnant women will transmit infection to their live offspring. The estimated global IMR (54.7) and 1-5 MR (30.1) mentioned earlier for the year 2000 almost entirely excludes HIV-related deaths, since these estimates are based on IMRs and trends in IMRs up to 1986, and HIV-associated deaths of children were not a major global contributor to childhood mortality on or before 1986. Therefore, these estimated rates may be viewed as global rates that likely would pertain in the absence of congenitally transmitted HIV infections. As maternal infection prevalence increases, the mortality burden will increasingly shift to those under age 5. For areas with high HIV rates in pregnant women, the child survival gains could be eliminated and even reversed. In some areas, all child survival gains since 1960 might become neutralized by the year 2000 because of AIDS.

IV. FUTURE POSSIBILITIES

There are gains, there are barriers. What is possible in the next decade? What can we realistically hope to see? It is likely that the standard Expanded Program on Immunization (EPI) program will be further expanded. Polio eradication has been adapted as a goal by the World Health Assembly. In some parts of the world, additional vaccines may be added on a country or regional basis. Other possibilities exist that must be evaluated for possible inclusion. In addition, the EPI activities have expanded to include applied research and development. This is a direct outcome of the Bellagio initiative. The member agencies identified current gaps, including the need to provide a systematic approach to applied or operational research. The Rockefeller Foundation and UNDP provided funding to WHO to develop a committee to review and provide priorities on research and development. Encouraging information is emerging on the possibility of a measles vaccine to be used at an earlier age; on new polio vaccine schedules; on self-destruct syringes that can only be used once; and on computer linkages to help coordinate various research projects. The pace has accelerated.

As we move into the next decade, the opportunities for expanded efforts to reduce needless loss of children have been outlined. In the Declaration of Talloires that came from the most recent meeting sponsored by The Task Force for Child Survival, a blueprint for the year 2000 has been identified. It includes continued efforts in EPI, but also recommends that the time is right to expand efforts to reduce deaths due to diarrheal diseases and acute respiratory infections. Like the Universal Childhood Immunization effort targeted to 1990, this next step targeted for the year 2000 will save tens of millions of children from death and disability.

Many non-governmental agencies are providing significant assistance in child survival efforts. Notable among these is Rotary International, a service club that has raised over $200 million to assist countries in the eradication of polio. However, the continued support of the American people, directly and through U.S. government programs and activities, is critical to the success of these plans. In addition, support for the United Nations agencies such as UNICEF, WHO, the United Nations Development Programme, and the World Bank will contribute to the development of sustained long-term gains in these areas.

Thank you.

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INFANT MORTALITY AND PER CAPITA GNP
UNITED STATES AND DEVELOPING COUNTRIES
1900 – 1995

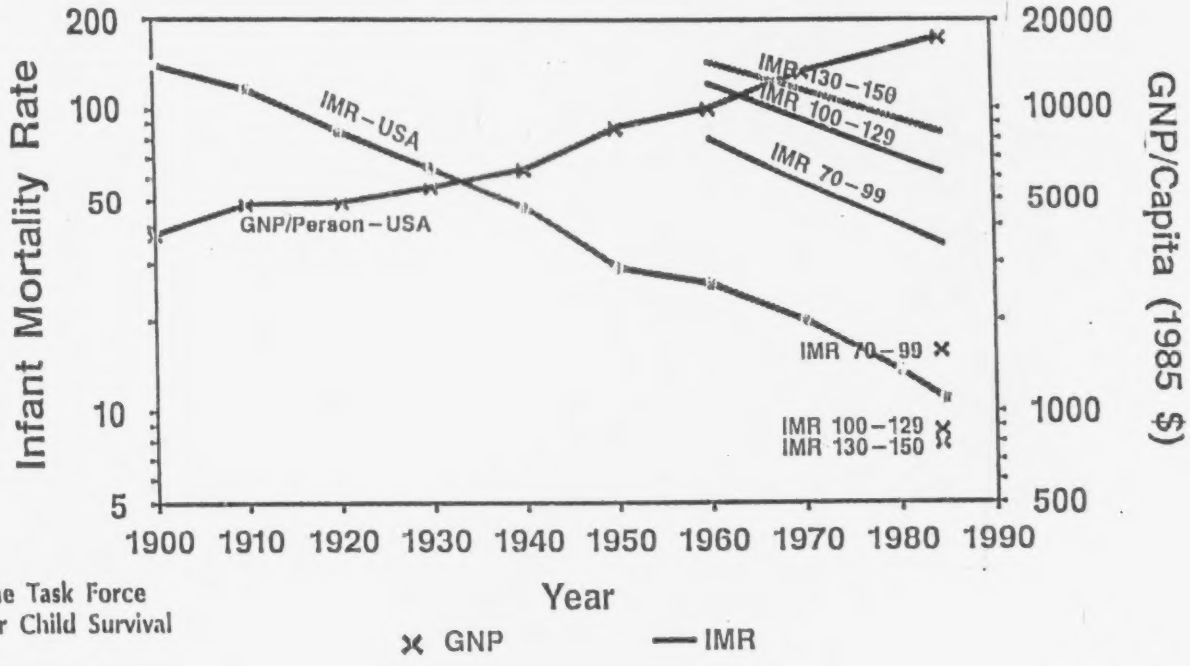

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FIGURE 1

NUMBER OF INFANT DEATHS AVOIDED IN 1986: A COMPARISON OF 1960 AND 1986 INFANT MORTALITY RATES

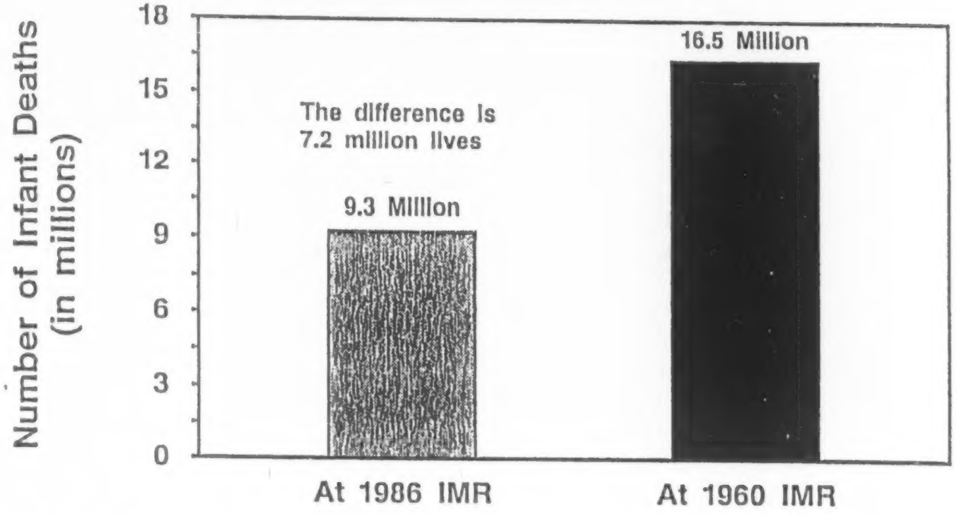

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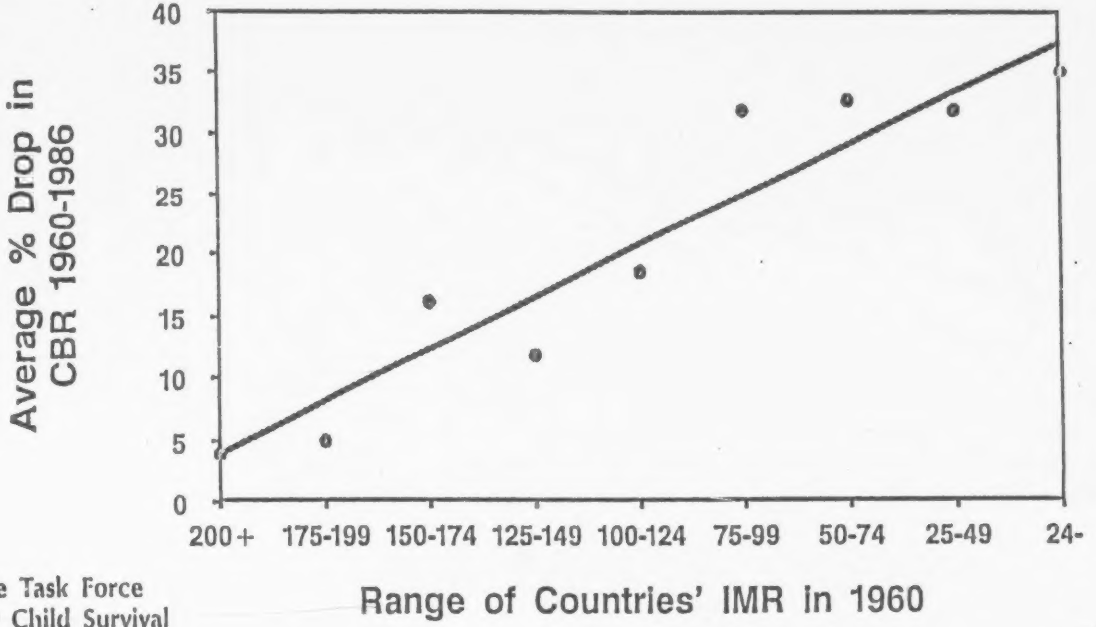
FIGURE 2

GLOBAL CHANGES IN CRUDE BIRTH RATES

1960 to 1986, by Initial IMR



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$r^2 = 0.91$

FIGURE 3

RISK OF A FAMILY LOSING A CHILD

By Number of Children

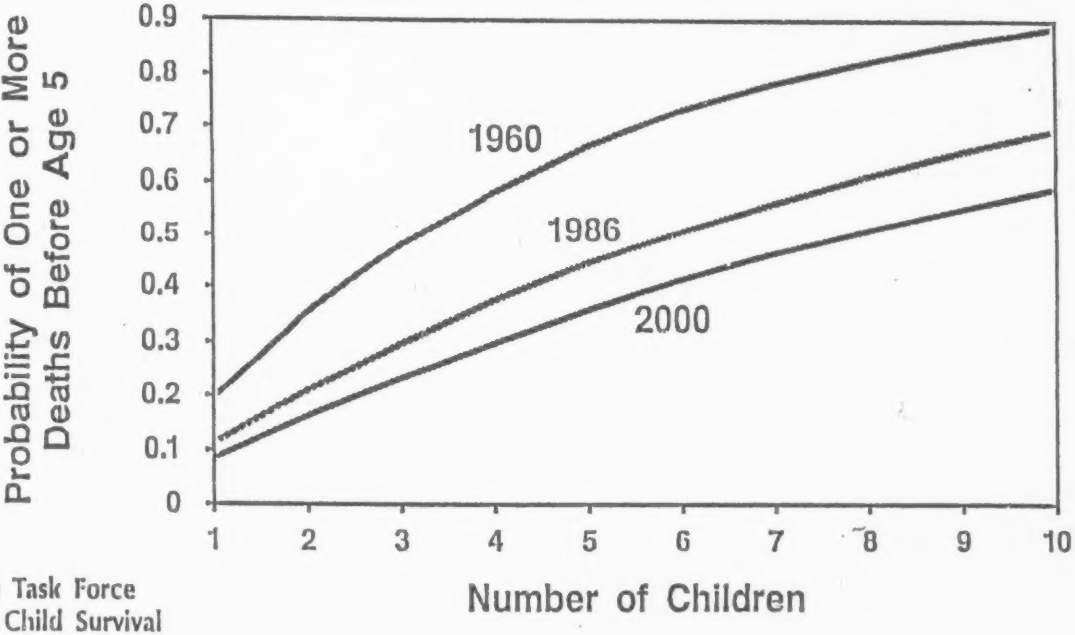

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FIGURE 4

Additional Questions for William Foege, M.D.

Submitted by Hon. Tony P. Hall

Question. You said that more than 7 million lives have been saved this year due to the progress since 1960 in reducing infant mortality. How many lives do you think we could save by the year 2000 if we went all out to end unnecessary child death?

Answer. If current trends continue, we can expect 144.2 million births, with 7.9 million infant deaths in the year 2000. If 1986 infant mortality rates are applied to year 2000 births, we would expect 10.8 million deaths instead of 7.9--or about 3 million more infant deaths per year. Of course, if new initiatives are introduced in an "all out" effort, the number of lives saved could increase.

Question. What are the most useful things we can do to make this a reality?

Answer. Immunization, oral rehydration therapy, acute respiratory infection management, breastfeeding, growth monitoring, birth spacing, and female literacy.

Question. You said that in some areas the disease AIDS may wipe out all the progress made in reducing infant mortality since 1980. What should we be doing to make sure that does not happen?

Answer. Ensuring a safe blood supply through donor testing, good blood banking practices, prevention of intravenous drug abuse and sexual transmission of HIV. Routine HIV tests for pregnant women, especially in areas with a high infection prevalence. Really, except for last item, this does not differ from control of AIDS per se.

PREPARED STATEMENT OF HERBERT A. PIGMAN, DIRECTOR, ROTARY INTERNATIONAL, IMMUNIZATION TASK FORCE

ROTARY'S POLIOPLUS PROGRAM

PolioPlus was created to support the Expanded Program on Immunization by providing polio vaccine and generating private sector support, through local Rotarians, for national immunization efforts. When PolioPlus was announced, Rotary International pledged to raise $120 million to provide a five-year supply of polio vaccine for newborns in developing countries. (In 1985, that commitment represented protecting 500 million children.)

On 24 May, 1988, at the Rotary International Convention in Philadelphia, Pennsylvania, Rotarians of the world learned that they had raised $220 million (now $230 million). The announcement followed by less than two weeks WHO's resolution to eradicate polio by the turn of the century.

The funds raised above the original goal will enable Rotary International to sustain the flow of polio vaccine beyond original commitments and to assist the greater goal of polio eradication.

The 1989-2000 push toward eradication will cost WHO an extraordinary $155 million over its current support for EPI. To help launch this effort, The Rotary Foundation of Rotary International allocated more than $5.3 million to WHO, through a special agreement, to fund a team of technical experts to help nations strengthen their technical capabilities for the work of eradicating polio.

Following Europe, the next region in the world where polio transmission probably will cease is the Americas. In 1985, the Pan

American Health Organization (PAHO) (WHO's regional office) predicted reaching the goal by the end of 1990. By the beginning of 1989, only 12 of 27 countries were reporting polio cases and the number of cases had plummeted. To insure success, PAHO proposed special "Mop Up" activities which, again, were supported by Rotary International. In November 1988, PolioPlus committed more than $1.2 million for the effort.

To date, more than $93 million in grants have been approved for 79 countries to support efforts to provide polio vaccine for some 454 million children. As many as 20 additional countries may be added to the PolioPlus roster and many recipient nations will be eligible for supplemental grants to sustain eradication efforts.

Most PolioPlus funds, approximately 92 percent, are spent for vaccine. Currently, PolioPlus is spending more than $1.2 million a month for vaccines, purchased through UNICEF or the Pan American Health Organization.

The heart of the PolioPlus story, however, lies in the 5 percent of program funds designated to support social mobilization. (The remaining 3 percent is for other support, such as cold chain equipment.) Social mobilization funds are directed to Rotarians in project countries for them to use to promote and assist national immunization efforts. Working in concert with ministries of health and representatives of WHO, UNICEF and other donor organizations, Rotarians are becoming increasingly effective in using these funds as "seed money"-- multiplying them many times over by enlisting support from news media, private firms and religious and educational leaders.

To cite a few examples:

* Mexican Rotarians annually generate an estimated $5 million worth of services supporting that nation's immunization days.

* Cote d'Ivoire Rotarians elicited more than $104,250 in private-sector donations to the 1987 rapid mass immunization effort in that country.

* In Guatemala, a simple promotional flyer, developed by the Rotary Club of Quetzaltenango and printed with funds from six local businesses, was credited with increasing coverage during a 1987 immunization effort.

* An Indian Rotarian with expertise in refrigeration surveyed the cold chain system for the state of Tamil Nadu and engaged private vendors to make hundreds of units operational.

The impact of PolioPlus cannot be measured solely by contributions of supplies for immunization, either through vaccines or Rotary-generated private sector support. Its real measure is its increasing effectiveness in building coalitions of volunteers, weaving them into health delivery systems, and creating advocates for accelerated immunization efforts. Only in the last two years have Rotarians begun to realize and to accomplish this aspect of PolioPlus as it has evolved from their personal involvement in polio eradication efforts.

Asked from the beginning to coordinate their efforts with other agencies and authorities, Rotarians found themselves introducing the concept of combining private sector expertise with the health establishment. As more resources were sought, ministries of health adopted social mobilization strategies and other volunteer groups became involved. Increasingly, Rotarians found themselves helping health workers coordinate those efforts. In 1988, in both Nigeria and Haiti, Rotarians were able to inject the assistance of thousands of volunteers into immunization efforts.

Rotary sponsors national PolioPlus workshops at which representatives of all participating agencies come together to brief Rotarians on immunization and help them plan their support efforts. Since September 1987, 54 national workshops have been held.

In populous countries with numerous Rotary clubs, national workshops are replicated at regional and local levels. Even a single Rotary club can make a difference, particularly in Africa where members typically represent all regions, tribal groups, and loyalties. Already experienced in working together, Rotarians help spark a team approach to immunization efforts.

Currently, in training workshops that are being conducted in some 1,400 communities throughout India, Rotary is recruiting 35,000 volunteers for a PolioPlus Immunization Task Force. Its members -- Rotarians, their family members and others -- will support the Indian health ministry's EPI program in enumeration, advocacy and immunization-post work. The special social mobilization work in India, as well as similar work in Nigeria, was made possible in part by a $6 million grant from the U.S. Agency for International Development. The award was a challenge grant to which U.S. Rotarians responded by raising more than $120 million.

The educative process inherent in national workshops yields an additional dividend: immunization advocates. Inspired by potential success, Rotarians increasingly stimulate government leaders at all levels to accelerate EPI programs.

In its brief life span, PolioPlus has become an effective partner in the drive for universal immunization. Instilling a team ethic is becoming one of the program's most important contributions. It seeks sustained support by relying on a stable and committed community of Rotarians. There are more than 8,000 Rotary clubs in the developing world, united by a common purpose with some 16,000 clubs in developed countries.

In its continuing efforts, Rotary's PolioPlus Program holds great promise. Each lesson learned is shared throughout Rotary's global network. It is hoped that this process will produce thousands upon thousands of men and women who will play a role as grass-roots volunteers for immunization.

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Additional Questions for Herb Pigman

Submitted by Hon. Tony P. Hall

1) Rotary is an exciting example of a private organization working effectively with the U.S. And foreign governments and other agencies. What lessons should we take away from this successful cooperation between the public and private sector in international humanitarian efforts?

Answer.

Our Rotary experience with polio eradication shows that a public-private partnership is essential for the success of this kind of social development program. The Rotary partnership is especially valuable in that it works to strengthen a government program both at the policy level and the operating level, in both the donor and recipient countries.

The PolioPlus Campaign is credited with being the critical influence on the international community to first consider, and then to agree upon the goal of eradicating polio globally. This recognition has shown the Rotarian community that it can have an impact well beyond its traditional activities. As such, it is a landmark development for Rotary which can serve as an example for other large service organizations. Additionally, the PolioPlus Program has enhanced the interest and understanding of an important segment of the American people in foreign aid as a legitimate and useful activity. Specifically, it has helped to reduce a common bias in the private sector against the use of U.S. funds for "soft" aid to foreign countries.

In the recipient countries (where Rotary is also active) the partnership has strengthened government level policy support for the Expanded Program for Immunization (EPI). This is because many Rotarians in these countries are in highly influential positions. At the operating level, the thousands of Rotarians working voluntarily at the city and village level have helped stimulate demand for vaccination services and facilitate the delivery of these services to the people.

2) What more needs to be done--by Rotary or any other group --to help eradicate polio by the turn of the century?

Answer.

Eradicating, versus control, of polio by the turn of the century will require a massive political commitment and the efforts of thousands of people, perhaps even greater than that which occurred for the eradication of smallpox. This is because polio is now much less visible to the people concerned than smallpox was, it is harder to detect in the critical early stages, and because the vaccine administration problems are more complex. At this time, much more active involvement of the private sector and donor organizations is needed to strengthen the political will, provide the additional foreign exchange costs (estimated by the World Health Organization to be $155 million above what is presently committed), and provide the manpower needed, not only to insure the achievement of EPI and related Child Survival goals but also to establish and operate the surveillance and follow-up systems required to eradicate the virus.

Research is needed to provide a more practical vaccine, one which can be administered in a single dose and whose efficacy is not so dependent upon the cold chain. Without such a vaccine, there may be significant delays in reaching the polio eradication target in Sub-Saharan Africa and South Asia.

3) You said in your testimony that you spend 5 percent of your fund to support "social mobilization." Please tell us more about why this has been so important.

Answer.

The PolioPlus funding for social mobilization is perhaps the most important component of Rotary International's contribution to the polio eradication program. This money is used to stimulate the essential volunteer activities of the thousands of Rotary clubs in the developing world to support the government EPI program in terms of strengthening national commitment at the policy level, generating public demand and facilitating service delivery at the operating level. Most commonly, the funds have been used to support workshops for government and private sector people which are designed to promote a practical working relationship and for development and distribution of information and educational materials along with promotion of community level activities. Our experience demonstrates that this volunteer effort has produced a positive impact on vaccination coverage and national policy level support. In some cases the EPI program has even been altered to accommodate the contribution of the Rotarians.

DECLARATION OF TALLOIRES
12 March, 1988

Remarkable progress in health has been achieved during the past decade. Global recognition that healthy children and healthy families are essential for human and national development is steadily increasing. Consensus has been reached on the strategy for providing primary health care programmes. The international community has become engaged in partnership with national governments in the creation of successful global programmes, ensuring the availability of financial support and appropriate technologies. These include:

1. *immunization programmes* which now protect over 50% of infants in developing countries with polio or DPT vaccines, preventing some 200,000 children from becoming paralyzed with poliomyelitis and over a million children each year from dying of measles, whooping cough, or neonatal tetanus;
2. *diarrhoeal diseases control programmes* which now make available for 60% of the developing world population life-saving fluids (particularly oral rehydration salts), the use of which may be preventing as many as a million deaths annually from diarrhoea;
3. *initiatives to control respiratory infections* which hold promise in the years ahead of averting many of the 3 million childhood deaths from acute respiratory infections occurring each year in developing countries and that are not prevented currently by immunization;
4. *safe motherhood and family planning programmes* which are so important in protecting the well-being of families.

Progress, to date, demonstrates that resources can be mobilized and that rapid and effective action can be taken to combat dangerous threats to the health of children and mothers, particularly in developing countries.

This progress is the result of:

- enthusiastic world-wide agreement on the development of health strategies based on primary health care;
- the commitment of national governments, multi- and bilateral development agencies, non-governmental organizations, private and voluntary groups, and people in all walks of life to give priority to these programmes;
- coordinated action by the sponsors of The Task Force for Child Survival: WHO, UNICEF, The World Bank, UNDP, and The Rockefeller Foundation.

We, The Task Force for Child Survival, conveners of the meeting "Protecting the World's Children — An Agenda for the 1990's" in Talloires, France, 10-12 March, 1988:

1. EXPRESS appreciation and admiration for the efforts made by the developing countries to reduce infant and child deaths through primary health care and child survival actions.
2. COMMIT OURSELVES to pursue and expand these initiatives in the 1990's.
3. URGE national governments, multi- and bilateral development agencies, United Nations agencies, non-governmental organizations, and private and voluntary groups to commit themselves to:
    - increase national resources from both developing and industrialized countries devoted to health in the context of overall development and self-reliance;
    - improve women's health and education, recognizing the importance for women themselves, recognizing women's contributions to national development, and recognizing that mothers are by far the most important primary health care workers;
    - accelerate progress to achieve universal childhood immunization by 1990 and to sustain it thereafter;
    - accelerate progress to eliminate or markedly reduce as public health problems the other main preventable causes of child and maternal mortality and morbidity, striving to reach sustained universal coverage of children and mothers by the year 2000;
    - assure the development of new vaccines and technologies and their application, particularly in developing countries, as they become appropriate for public health use;
    - promote expanded coverage of water supply and sanitation;
    - pursue research and development, including technology transfer, in support of the above actions.
4. SUGGEST that the following be considered by national and international bodies as targets to be achieved by the year 2000:
    - the global eradication of poliomyelitis;
    - the virtual elimination of neonatal tetanus deaths;
    - a 90% reduction in measles cases and a 95% reduction in measles deaths compared with pre-immunization levels;
    - a 70% reduction in the 7.4 million annual deaths due to diarrhoea in children under the age of 5 years that would occur in the year 2000 in the absence of oral rehydration therapy, and a 25% reduction in the diarrhoea incidence rate;
    - a 25% reduction in case/fatality rates associated with acute respiratory infection in children under 5 years;
    - reduction of infant and under-5 child mortality rates in all countries by at least half (1980-2000), or to 50 and 70 per 1,000 live births respectively, whichever achieves the greater reduction;
    - reduction of current maternal mortality rates in all countries by at least half.

    Achievement of these strategies would result in the avoidance of tens of millions of child deaths and disabilities by the year 2000, as well as a balanced population growth as parents become more confident their children will survive and develop. The eradication of poliomyelitis would, with the eradication of smallpox, represent a fitting gift from the 20th to the 21st century.
5. DRAW world attention to the potential *for enlarging* upon the successes outlined above to encompass low-cost, effective initiatives to:
    - improve the quality and coverage of educational services so as to obtain universal primary education and 80% female literacy, and
    - reduce to less than 1% severe malnutrition in children under 5 while also significantly reducing moderate and mild malnutrition in each country.
6. WELCOME the progress being made in drafting the Convention on the Rights of the Child and join the United Nations General Assembly in urging completion of the Convention in 1989, the 10th anniversary of the International Year of the Child.

We are convinced that vigorous pursuit of these initiatives aimed at protecting the world's children will ensure that children and mothers — indeed whole families — will benefit from the best of available health technologies, making an essential contribution to human and national development and to the attainment of Health For All By The Year 2000.

—Talloires, France